



Providing meaningful care: using the experiences of young suicidal men to inform mental health care services: Research Report

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Providing meaningful care: using the experiences of young suicidal men to inform mental health care services



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Executive Summary

Background

Suicide is the act of deliberately ending one's own life and is among the top 20 leading causes of death globally for all ages. Every year almost one million people die by suicide, a 'global' mortality rate of 16 per 100, 000 or one death every 40 seconds. Before 1950 suicides were more common in people over 45 years of age. In the latter half of the 20th century this pattern changed significantly, so that the majority of suicides were within the 15-45 age range. One of the most important factors underpinning this shift in age related trends was the epidemic rise in suicide among young men in most industrialised nations. Significantly, rates of suicide in young men have shown evidence of decline since the late 1990s across most of the industrialised West.

In comparison to the trends identified above, the rise in suicide in Northern Ireland in general, as well as in relation to young men, is a more recent phenomenon. After remaining relatively static throughout the latter half of the 20th century, between 1999 and 2008, there was a 64% increase in suicide in Northern Ireland. In large part the dramatic increase has been fuelled by a rise in male suicide, particularly marked in the 15-34 year age group. In 2002, almost 76% of all suicides were male, with 60% of these occurring in the 15-34 year age group; by 2008, 77% of all suicides were male and the percentage occurring in the 15-34 age group had increased to 72%.

The alarming rise in suicide, particularly among young men, prompted the DHSSPS to produce the first ever local-level Northern Ireland Suicide Prevention Strategy, 'Protect Life-A Shared Vision' (DHSSPS, 2006). Included in this strategy is an acknowledgement of the need for research to inform the development of policy as well as local-level service provision. The study reported here was one such research initiative funded by Health and Social Care Research & Development Division of the Public Health Agency. It was a collaborative investigation between the Queens University, Belfast and the

University of Ulster focused on those areas of Northern Ireland evidencing some of highest rates of suicide among the male population in the 16 to 34 age group.

Aims

The overarching aim of the study was to obtain a comprehensive understanding of the experiences of suicidal men aged 16-34 to underpin the provision of accessible, acceptable and appropriate mental health services. In line with this aim, study objectives were to:

- elicit the experiences of men (aged 16-34) of being suicidal and their understandings of what would constitute meaningful caring
- explicate the specific caring processes that might make 'a difference' to caring for the suicidal person, that is, to inform what health care professionals can do.

The above aims and objectives were developed in order to answer two guiding research questions:

- How can mental health care services be most appropriately configured to encourage their use by suicidal men aged 16-34?
- What is the required response of mental health care services for suicidal men, aged 16-34?

Methods

An underpinning conceptualization of suicide as a multidimensional, complex phenomenon was reflected in the choice of a qualitative research design for this study. The fact that relatively little is known about young men's experiences of suicide further validated this approach. Consequently, in-depth interviews were chosen as the means of data collection. A purposive sample of young men was obtained according to: (i) age range and (ii) contact/lack of contact with statutory and non-statutory mental health services. The final sampling frame targeted four 'categories' of young suicidal men, defined primarily in relation to their (non) engagement with services. These were:

- *Men aged 16-34 currently engaged with statutory mental health services:* access was obtained through both the Belfast HSC Trust and Southern HSC Trust
- *Men aged 16-34 previously engaged with statutory mental health services:* access was to be obtained through both the Belfast HSC Trust and Southern HSC Trust.
- *Men aged 16-34 currently using a range of non-statutory counselling organisations:* access was obtained through a wide range of local-level community sector counselling organisations that dealt with suicidal young men in both the Belfast HSC Trust and Southern HSC Trust areas.
- *Men aged 16-34 who had not had any contact with statutory or non-statutory mental health services:* access was obtained through a comprehensive advertising campaign across a range of media.

A total of 36 young men were subsequently recruited. Data were collected by means of semi-structured interviews. All interviews were audio-recorded, with permission. Although questions were determined primarily by the unfolding discussion between the interviewer and participant, a limited number of pre-specified issues were introduced. These included: a question addressing the support, including both formal and/or informal (mental) health care services, which a participant had sought, and; a question addressing the factors that had helped and continued to help maintain his wish to stay alive.

The overarching aim of the data analysis was to achieve *explanatory* value in terms of understanding suicidal behavior amongst young men. That is, analysis needed to move beyond the mere description of recurrent or common 'themes' to one that explored the context of and relationships between these themes (and their constituent 'properties' and associated concepts). Consequently, an interpretive thematic content analysis was undertaken.

Findings

Three 'core categories' were developed: *Widening Access and Bolstering Pro-active Outreach*, *On becoming a man...*, and *Equipping young men for the challenges of 21st century living*. Collectively, these categories answered the two research questions.

Widening Access and Bolstering Pro-Active Outreach

Essentially, this category is concerned with current formal mental health services. Findings indicated that the type, nature, and geographical location of these services offered only limited help to address young men's suicidal thoughts and behaviours. Importantly, there was a clear need for more 'pro-active', 'outreach', suicide prevention services in addition to/distinct from responsive or reactive suicide services. In keeping with such a development was the parallel need for increasing awareness in the community, including young men, of the existence of such services. Further, the data highlighted how any media-based outreach attempts could profitably make use of technology more appropriate to the younger age group (for example, the internet, 'text messaging', email). In addition, findings confirmed the value in creating (more) community-based and relatively informal 'drop-in' suicide centres in line with young men's preferred contexts of (social) interaction.

The category also addresses the particular qualities and skills that young suicidal men found helpful in people with whom they worked. Especially in relation to the initial stage of the process of recovery, young suicidal men placed immense emphasis on such qualities and skills which emerged as the principal 'interventions' that the Mental Health Practitioners (MHPs) made use of. A firm interpersonal connection not only served as the platform upon which all future interventions were built but was made possible because of the practitioner possessing and, importantly, communicating certain attitudes. Finally, this category is concerned with initial attempts to combat the pervasive sense of disconnection referred to by the young men in the study. Their accounts indicated that having a sense that they mattered, that someone else was concerned about and interested in them, was immensely important and had a specific countering effect on their suicidal ideation and perspectives.

On Becoming a Man ...

Participants described a range of issues, problems and perceptions that were significantly contributing to their initial and ongoing increased risk for suicide. Accordingly, this category is concerned with the interventions and services that could be provided to young men as a means of alleviating this risk. Participants made reference to possessing certain perceptions of what it was to be a 'successful' man in 21st century Northern Ireland. These perceptions were, by and large, unhelpful and unrealistic and served to contribute to their low self-esteem, level of personal stress and ultimately, to their increased risk of suicide. Accordingly, one role of MHPs was to gently challenge these constructs and perceptions and replace them with more realistic, helpful and attainable views of being a successful man.

Further, study data suggested the relevance of being able to access a 'peer group' within which young men can find support and hope from mixing with survivors of suicide. Being amongst others who were 'the same' created an opportunity for the young men to vocalize their feelings and behaviours in what was perceived as a 'safe' forum. Further, hearing the testimonies of other (formerly suicidal) young men highlighted the possibility of recovery and provided some form of conceptual understanding of the likely processes involved. Additionally, being exposed to these testimonies served as a protective factor, in that learning of the 'pain' of suicide from (multiple) others directly ushered the suicidal young men towards an understanding of suicide as unacceptable.

Finally, this category addresses suicidal young men's requirement for counselling (therapy) to address specific, unresolved issues. Participants referred to a wide variety of problems and issues each of which, to a greater or lesser extent, was contributing to their risk for suicide. Accordingly, a wide variety of forms or types of counselling services were required (for example, for abusive childhood, relationship/marriage problems, addictions and dependency, loss and bereavement and family

dysfunctionality). Evidently, where suicidal young men had received such specific forms of counselling help, they found it useful.

Equipping Young Men for the Challenges of 21st Century Living

This category is concerned with the processes and activities with which the young men engaged on their path to recovery from suicidality. It captures how this 'journey' was seldom completed quickly or easily and that recovery involved a process of establishing meaning in the young men's lives. Individual ways through which this (new) meaning was generated varied, but there were distinct commonalities across participants. In the context of their increasing sense of dissatisfaction with a 'meaningless life', MHPs could play an important role in helping the young men (re)discover personally meaningful phenomenon and experiences. As a result of finding this (new) meaning and purpose, the elevated risk of suicide appeared to diminish. Furthermore and importantly, participants found meaning in 'doing for other people', particularly other people who were experiencing similar challenges. Accordingly, there appears to be particular utility and value (as a suicide deterrent) to be involved in helping other people overcome their own challenges with suicidal thinking and actions.

The category is also concerned with providing suicidal young men with a range of opportunities to engage in pragmatic life skills, social skills, educational programmes and other meaningful activities. All of these, to a greater or lesser extent, provide them with a wide range of skills required to navigate their way successfully through the contemporary challenges of life in Northern Ireland. Further, such opportunities play an important role in keeping the young men occupied, thereby avoiding exposure to excessive isolation and rumination. Additionally, the category reflects suicidal young men's (growing) awareness of the powerful protective factor that having close, loving, concerned 'significant others' (most especially, family) can provide. Moreover, participants needed to be aware that their suicidal behavior had been accepted by these others; such acceptance affected their outlook, making them feel more hopeful about the future.

Finally, the category highlights the suicidal young men's acknowledgement of 'recovery' from their suicidality as an ongoing and long-term process and that within this extended time frame, 'hard work' on their part would be required. There is also a strong sense that while they were willing to engage in this long-term work, they would require ongoing support from mental health services and others who have endured a similar situation. To a lesser extent, this category is also concerned with the participants, in essence, 'learning to live' again. This included the important process of 'making sense' of their suicidality; interestingly, none of the young men referred to this process of 'sense making' in the past tense or as something they had completed. Additionally, it was evident that a number of inter and intra-personal processes were involved, not least the continued support from and involvement of (in this instance) the MHPs and fellow 'travelers' on the 'recovery' path.

Recommendations

In the following, the two original research questions are used to structure study findings in terms of what they suggest as relevant to the provision of care for young suicidal men.

(1) How can mental health care services be most appropriately configured to encourage their use by suicidal men aged 16-34?

- Suicide related services need to reach out to young men *pro-actively*. These services should be community based and open-access.
- Part of this pro-active, community level service provision should be embedded in manifestly non 'mental health' contexts. These include sports clubs, schools, the workplace and community interest/self-help groups.
- Services, particularly those based in the community, need to be advertised more widely and in ways which reach out to young men. A range of media should be used to promote access and provide culturally relevant care, including media which have become a regular means of communication amongst young people.
- Services should be premised on an acknowledgement of the need for support to be provided to young men over the long-term so that they are to be enabled to

move forward with their lives in a positive manner once the initial risk of suicide has been removed.

- Novel forms of suicide prevention outreach work should include those media that have become a regular means of communication among young people. This includes social networking systems, the Internet, 'text messaging' and/or email.
- Services must continue to address the concerns of young men about issues of stigma and confidentiality regarding the care and treatment of suicidality. Some issues around signposting and labeling of suicide prevention services should be addressed immediately.
- Care should be based on a broad Recovery approach. The need to skill and support young men operates at both an individual and societal level and a fundamental part of this must involve creating an appropriate environment to promote participation and social inclusion of young suicidal men generally.
- Irrespective of the particular form of care/service provision, help and support needs to be delivered by those appropriately skilled and resourced.

(2) What is the required response of mental health care services for suicidal men, aged 16-34?

- It is essential that health care professionals care for young suicidal men in ways which respond to their basic emotional and interpersonal needs. It should be ensured that health professionals possess and convey therapeutic and supportive (non-judgemental) attitudes and realise the important bonding role they have in enabling young men to *reconnect with humanity*.
- Health care professionals should appreciate that their demeanour and attitude is crucial to a young man's sense of meaningful therapeutic engagement. Effective care is as much about how a young man perceives the relationship between himself and professional carer as it is about the 'technical' components of care.
- Care should be premised on an explicit acknowledgement of a young man as a human being with a unique personal biography.

- It should be ensured that treatment and care is relevant to recovery and onward trajectory through life if it is to be perceived as effective by young men. As part of this sense of 'moving forward', care should include help and support to develop a realistic appreciation of the (personal) possibilities that life offers as well as the skills to pursue these possibilities once envisaged.
- People with experience of suicide should be involved in care delivery and support. Hearing *first-hand* about these experiences serves as a powerful disincentive to suicide and learning about lives built successfully thereafter can act as an incentive for/basis of personal growth and development.
- Psychological therapies need to be made available as part of routine care, particularly those that equip young men with fundamental cognitive resources, including coping strategies (e.g. for dealing with stress, anxiety and disappointment) as well as other dimensions of mental/emotional well-being such as, for example, self-esteem.
- Maximising access must include taking steps to address the major challenges posed by stigma and discrimination, including comprehensive, population-level advertising and awareness raising campaigns as well as more targeted educational and workplace initiatives.
- Care should be premised on a Recovery rather than a 'risk reduction' approach.
- Additional education/training needs to be provided to health care professionals in order to support the provision of relevant care to young suicidal men.

Chapter One: Introduction

Suicide is the act of deliberately ending one's own life and is among the top 20 leading causes of death globally for all ages (WHO, 2009, (http://www.who.int/mental_health/prevention/suicide_rates/en/index.html)). Every year almost one million people die by suicide, a 'global' mortality rate of 16 per 100, 000 or one death every 40 seconds. A recent paper in the New Scientist estimated suicide to account for approximately 1.5% of all deaths worldwide, following a 60% increase in global suicide since 1965 (Pool, 2009) . Trend data show that it is now among the three leading causes of death among those aged 15-44 years in several countries and the second leading cause of death in the 10-24 age group (WHO, 2009). However, the successful suicide statistics hide a deeper problem with twenty uncompleted suicide attempts for every successful one (Pool, 2009)

The worldwide trend in suicide continues upward with eastern European countries displaying some of the highest recorded rates. Belarus has 63.3 suicides per 100,000 males and 10.3 per 100,000 females, followed closely by Lithuania with rates per 100,000 of 53.9 and 9.8 respectively. Caribbean countries have some of the lowest rates in the world (e.g. Barbados, 1.4 suicides per 100,000 males). Current UK figures are 10.1 per 100,000 males and 2.8 per 100,000 females and those of Ireland are 17.4 per 100,000 males and 3.8 per 100,000 females. These statistics are interesting but it must be stressed that because of the stigma surrounding suicide, often related to prevailing religious beliefs, it is possible that suicide remains under-reported; this may account, for example, for the low rates recorded for the Philippines and Iran (OECD, 2010; WHO, 2009).

The WHO (2009) figures also show that before 1950 suicides were more common in people over 45 years of age, representing 60% of all suicides. Between 1950 and 2000 this pattern changed significantly, so that 55% of all recorded suicides were within the 15-45 age range. One of the most important factors underpinning this shift in age

related trends in the latter half of the 20th century has been the epidemic rise in suicide among young men in most industrialised nations (Cantor, 2000). For example, rates of suicide in men under 45 years old doubled in England and Wales throughout 1950-1998 while rates in women and older men declined. During the 1990s, rates for young men aged 15-24 reached an all time high and were at their highest since the 1920s in men aged 25-34 years (Gunnell *et al.*, 2003). Taken overall, suicide accounted for about a fifth of all deaths in young men (Brock & Griffiths, 2003). A similar pattern is observable for Scotland, where rates of suicide / undetermined death throughout 1980-2000 rose by a staggering 97% amongst 15-24 year olds and by 86% amongst 25-34 year olds (Stark *et al.*, 2008). Since the late 1990s rates of suicide in young men across the industrialised West have declined (Levi *et al.*, 2003). After a sustained increase in Australian young male suicide rates over the previous 30 years, there has been a dramatic reduction amongst the 20-34 year age group, declining from approximately 40 per 100,000 in 1997/1998 to approximately 20 per 100,000 in 2003 (Morrell *et al.*, 2007). By 2005, they were at their lowest level in England and Wales for approximately 30 years; rates in men aged 15-24 fell to almost half the peak rate and those in men aged 25-34 had decreased by almost one-third (Biddle *et al.*, 2008). In Scotland, a marked reduction occurred in the 15-29 year old age group, from 42.5 per 100,000 in 2000 to 24.5 per 100,000, representing a 42% decrease (Stark *et al.*, 2008). Whilst the figures for the USA are limited, recent evidence suggests a reduction in adolescent male suicide in the recent past (Bridge *et al.*, 2005).

In comparison to the trends identified above, the rise in suicide in Northern Ireland in general, as well as in relation to young men, is a more recent phenomenon, beginning in the late 1990s and still ongoing. Thus, after remaining relatively static throughout the latter half of the 20th century, between 1999 and 2008, there was a 64% increase in suicide in Northern Ireland (Samaritans, 2009). Northern Ireland now has more suicides per 100,000 persons than England and Wales, but less than our close neighbours, Scotland and the Republic of Ireland (DHSSPS, 2006). In large part the dramatic increase has been fuelled by a rise in male suicide, particularly marked in the 15-34 year age group. The sustained nature of this increase in young male suicide is

demonstrated by the following figures: in 2002, almost 76% of all suicides were male, with 60% of these occurring in the 15-34 year age group; by 2008 77% of all suicides were by males but the percentage occurring in the 15-34 age group had increased to 72% (Samaritans, 2009). Other sources confirm this dramatic increase in young male suicide. According to the Department of Health, Social Services and Public Safety (DHSSPS) in Northern Ireland, in recent times there have been approximately 150 suicides each year in the province, 41% of which are single males and some 22% of suicides are by males aged between 25 and 34 (DHSSPS, 2006).

A related but worrying trend in Northern Ireland is the high rates of self harm (CAWT, 2010). While it is acknowledged that people who participate in self harm may not necessarily wish to die by suicide, there is considerable evidence to show how large numbers of people who die by suicide have been undertaking self harm for a period before their deaths. The organisation Co-Operation and Working Together (CAWT, 2010) helped produce a Northern Ireland Registry of Deliberate Self Harm. The report states that self-harm represents extensive psychosocial distress and is the most important risk factor for future suicide. In contrast to suicide, at 53.1%, the highest rates of self-harm tend to be among females. The age range also differs across the sexes with self harm higher among 35-44 year old females and 25-34 year old males.

In the north west of Northern Ireland, Derry City Council area has rates of self harm of 611 per 100,000 of population. This is the highest rate in these islands and much higher than cities such like Limerick (529), Cork (394), Manchester (527), Oxford (314), Leeds (333), Galway (361), Dublin (252) or Waterford (335). Drug overdose is the most common method of self harm followed by cutting, drowning and hanging. In 2007 alcohol was involved in 57% of cases, but increased significantly in 2008 to reach 69% (CAWT, 2010). While these figures focus only on the north west of Northern Ireland, other areas such as north and west Belfast and the Craigavon/Banbridge area also are experiencing higher than average rates of suicide in (young) men.

Figures from the 'Protect Life' Document (DHSSPS, 2006) show that in the Belfast Trust area there were 16 deaths by suicide among young men aged 15 – 34 years in the year

1998. This increased to 30 deaths in 2008. The average across these years was 17 deaths per year for this age range. In the same timeframe and for the same age range the average was 13.5 across the Northern Trust, 11.6 across the South Eastern Trust, 12.8 across the Southern Trust and 11.5 across the Western Trust.

The alarming rise in suicide, particularly among young men, prompted the DHSSPS to produce the first ever local-level Northern Ireland Suicide Prevention Strategy, 'Protect Life – A Shared Vision' (DHSSPS, 2006). It seeks to tackle the issue of suicide and self-harm on a range of fronts and with actions targeting both the general population and those individuals and communities most at risk. Included in this strategy is an acknowledgement of the need for research to inform the development of policy as well as local-level service provision. The study reported here is one such research initiative funded by Health and Social Care Research & Development Division of the Public Health Agency. It is a collaborative investigation between the Queens University, Belfast and the University of Ulster focused on those areas of Northern Ireland evidencing some of highest rates of suicide among the male population in the 16 to 34 age group.

The overarching aim of the study is to obtain a comprehensive understanding of the experiences of suicidal men aged 16-34 to underpin the provision of accessible, acceptable and appropriate mental health services. In line with this aim and given the relative lack of evidence concerning protective factors for suicide, the research seeks to uncover young men's understandings of how they have gone on living after a serious suicide attempt and to use these testimonies to further consider the provision of relevant services. The structure of this report is as follows. Chapter Two provides an overview of the literature, Chapter Three provides detail on research design and implementation, Chapter Four outlines the research findings and Chapter Five focuses on the interpretation of results, implications and recommendations.

Chapter Two: Literature Review

2.1 Background

It is clear from the literature that much research into suicide to date has been rooted firmly in the scientific paradigm, with an emphasis on quantitative methods and concern with prediction and control (Canadian Institutes for Health Research (CIHR)/Health Canada, 2003; McIntosh, 2002; Department of Public Health, 2001; Silverman, 1997). Although this research has been valuable in exploring the epidemiology of suicide, the body of knowledge that has resulted is far from unequivocal, with variation in, for example, identified risk factors, causal links and suggested methods of prevention (Althaus & Hegerl, 2003; Crowley *et al.*, 2004; Silverman, 1997). Indeed, Crowley *et al.* (2004) recently concluded that there is little evidence for a range of interventions in relation to youth suicide. The lack of research evidence they identify extends to that which might help guide professionals about how to engage interpersonally with those at risk (Cutcliffe & Links, 2008).

There are few published studies detailing qualitative research into people's experiences of suicide and fewer still on young men's experiences of suicide and their experiences of services while suicidal.

In the early 20th century Durkheim and Freud put forward explanations on suicide. Durkheim viewed the causes of suicide in social terms while Freud believed suicide was rooted in instinctual drives which he termed the 'death instinct'. Recent explanations have tended to focus on depression, hopelessness and emotional distress but none have managed to answer the question as to why some people kill themselves and others do not, even when in similar circumstances (Pool, 2009).

The latest theory on suicide was put forward by Joiner in 2005. He proposed that people who kill themselves must meet two sets of conditions in addition to feeling depressed and hopeless. Firstly, they must have a strong desire to die. Joiner stated that this is evident when three conditions are present – when people feel they are a burden on

those around them (perceived burdensomeness, when there is a feeling of isolation from people who could otherwise provide a sense of belonging (thwarted belongingness) and being capable of the deed of killing themselves (acquired capability for suicide). He maintained that no matter how much someone wants to die, killing yourself is not an easy thing to do as the self-preservation instinct is too strong (Joiner, 2005).

The Centre for Suicide Prevention (2009) in Canada recently published a paper detailing the factors contributing to suicide attempts. Among the findings were seven themes as follows: lack of connection, control, coping, escape or relief, negative emotions, negative self-perception and interpersonal problems and conflicts. These themes reflect the findings of the studies detailed within the following review of the limited literature in this area.

2.2 Search Strategy

The existing literature was searched from 2000 to 2009 using a pre-defined search strategy. Keywords used to search the literature included 'intervention', 'suicide (and all variants)', 'attitudes', 'behaviours', 'suicide and interventions' 'young men/male/adolescent'. Electronic databases were targeted including *Medline*, *PubMed*, *Web of Science*, *Cinahl*, the *British Nursing Index*, *ProQuest* and *PschInfo*.

This brief review of the literature will focus on the following:

- What does research to date uncover regarding young men's experience of suicide?
- What research has been undertaken into services for young men who may be suicidal and in need of help?
- What interventions are there and how effective have these been?

2.3 Young Men's Experience of Suicide

After a comprehensive review of the published literature in English, no papers were found that directly and exclusively related to the experience of suicide among young men aged 16-34 years. However, research undertaken by De Leo *et al.* (2005) does provide some insight into suicidal ideation among young people aged 25-44 years. The study used telephone interviews with 11,572 people within the general population in Australia. Those individuals identified as reporting suicidal ideation or attempts at suicide were sent a further postal survey (n=1,311) after consent had been gained. The survey aimed to ascertain the 'possible development of that behaviour along a continuum, psychiatric and psychological factors, suicidal transmission, help-seeking and service utilisation' (p.215). Findings showed that suicidal ideation and attempts prevailed in individuals aged 25-44 years of age and declined in older individuals. The knowledge of someone else's suicide or suicidal behaviour increased the risk of the individual attempting suicide themselves. Half of the participants abused alcohol and a third engaged in other risky behaviours such as using drugs or dangerous driving. Forty percent stated that relationship problems (partner) were a major factor in their suicidal behaviour, followed by financial difficulties (24%), parental problems (23%) and difficulties with social relationship (22%). Male participants were more likely to report disability, physical illness, unemployment, addiction or legal problems. Females were more likely to report sexual abuse as a factor.

Hidaka *et al.* (2008) reported on a study in Japan that assessed the prevalence of attempted suicide and explored the individual, interpersonal, behavioural and psychological risk factors in a sample of young people. Some of their findings are relevant to the experience of young men and suicide. In total, 2,095 participants took part, aged between 15 and 24 years. Six percent of male participants reported a previous suicide attempt. For these, attempted suicide was associated with bullying, being homosexual or bisexual, drug use, sexual abuse and low self-esteem. The authors concluded that more 'theoretical constructions of specific mechanisms and pathways towards risk for attempted suicide are warranted in order to build intervention strategies' (p.756).

2.4 Experiences of Services

Few research papers were uncovered in relation to services provided for people who may be suicidal. Owens *et al.* (2005) aimed to explore how distressed individuals and members of their close family and friendship network had made decisions to seek or not to seek help from a health professional in the period leading up to suicide. It should be noted that this study was focused on psychological autopsy data. Semi-structured interviews were undertaken with close relatives and friends of the person who had died by suicide (n=66). Findings showed that family and friends often played a role in determining whether suicidal individuals sought help. Findings demonstrated that half of the sample (n=33) sought help in the final month before their suicide, with the conclusion drawn that family or a friend had persuaded them to do so. The authors of this study concluded that greater attention needs to be paid to the potential role of lay networks (family and friends) in managing psychological distress and preventing suicide. The paper also stated that little is known about why so few suicidal people seek professional help at their time of crisis.

Another study in Australia examined how well informed General Practitioners (GP) were about adolescent suicide (Smith & Scoullar, 2001). The reason for the inclusion of this paper is that some of the sample in the current study would be regarded as adolescent (15-18 years). The researchers assessed GPs knowledge using the 39-item Adolescent Suicide Behaviour Questionnaire (ASBQ) which was sent to all registered GPs in the state of Victoria, Australia. The response rate was 43% (n=1,694). Findings showed that GPs, on average, got 71% of the questionnaire items correct. However, there were wide variations in the numbers of correct scores ranging from as few as four items correct to 38 items correct (100%). The authors concluded that while Australian GPs are moderately well informed about adolescent suicide, the extent of the variability in knowledge is a cause for concern. Conclusions also pointed to the need for ongoing education for GPs in prevention strategies for adolescent suicide.

Research referred to previously, also undertaken in Australia, provided insight into help-seeking behaviours and experiences with health services (De Leo *et al.*, 2005). Most participants in De Leo *et al.*'s (2005) study, as discussed above (see page 22), were designated as 'suicide planners' (n=506) did not seek formal help (53%). Of those who did seek help, 11% used a helpline, 59% visited their GP and 30% saw a counsellor or psychiatrist. Reasons given for those 'suicide planners' who did not seek help included feeling that they did not need help (14%), did not want to bother anyone (12%), had no confidence in the help available (13%), were worried about what other people would think (13%) and did not know where to go (9%). More male than female participants stated that they did not perceive a need to seek help. In relation to 'suicide attempters' (n=399), 42% sought formal help; 28% received treatment at hospital, 19% saw their GP and 14% received counseling.

Howerton *et al.* (2007) reported on the findings of a study designed to understand help-seeking behavior among male offenders. Thirty-five male offenders aged between 18-52 years were interviewed and a quarter of these were considered at risk from self-harm. Findings showed that most offenders stated that they would not seek help from a GP or other healthcare professional if they were experiencing mental health problems. Reasons given for this reluctance included not wanting to be labeled as having a mental illness, lack of trust of healthcare professionals and distrust in the system.

No further relevant articles were identified within the confines of the search strategy. The current study includes a focus on young men's experiences of services in relation to their suicidal behavior. There would appear to be no comparative studies within the existing literature within the last ten years.

2.5 Interventions

Within the current literature, there are two types of interventions relating to suicide. Firstly, those concerned with the training of health professionals (Chan *et al.*, 2008; Brunero *et al.*, 2008; Murray & Wright, 2006; Valente & Saunders, 2004) and training of individuals in the community to identify suicidal behaviour and risk (Goldney *et al.* 2008; Gask *et al.* 2008; Chagnon *et al.* 2007). Second, direct interventions with young people, the general population or specific groups of patients in order to prevent suicide. This section will outline the latter type of intervention as this is the area which is relevant to the current study. A number of empirical research studies and reviews are included.

2.5.1 Empirical Research

In 2000, Burns and Patton reviewed the current knowledge of risk for youth suicide in Australia. Their aim was to categorise strategies for intervention and to provide evidence on the 'best' preventive interventions for youth suicide (p.388). Findings showed that there was a 'paucity' of evidence on the effects of interventions relating to suicide. The authors also concluded that there had been a neglect of evaluation of many interventions. Since then, many studies have been undertaken on specific types of intervention. Only those relevant to the sample in the current study sample will be reviewed here.

Stuart *et al.* (2003) stated that reviews of suicide prevention programmes had shown conflicting results on the efficacy of school based prevention programmes for youth suicide. This paper reported on gatekeeper training and peer helping with youth in Canada. It showed positive gains in knowledge about suicide and skills for 'responding to suicidal peers' (p.321) immediately after training and at a three month follow up. Additionally, a significant improvement was reported in positive attitudes towards suicide interventions. No control group was used but the authors concluded that the research offered 'tentative support for the efficacy of training peer helpers in suicide risk assessment' (p.321)

Nordentoft *et al.* (2005) undertook research into the effect of a suicide prevention centre for young people with suicidal behaviour in Copenhagen, Denmark. The study had a quasi-experimental design and used a sample of 362 patients in the centre and a comparison group of 39 patients. The intervention was a two-week programme of social and psychological treatment based on Cognitive Behavioural Therapy (CBT). All participants were interviewed using the European Parasuicide Study Interviewer Schedule I (EPSIS I), invited to participate in a follow up interview using EPSIS II at the one year point and followed within the National Patients' Register and the Cause of Death Register in Denmark. Results showed that at the one year follow up, the patients who had received the intervention showed a significant improvement in the Beck's Depression Inventory, Beck's Hopelessness Scale, Rosenberg's Self-Esteem Scale and CAGE-score. The authors concluded that the intervention had a positive effect and that it was likely that the improvement in the intervention group was facilitated by the CBT programme.

A study undertaken in America evaluated the Signs of Suicide (SOS) suicide prevention programme, comprising of an intervention implemented in schools and aimed at reducing suicidal behaviour (Aseltine *et al.*, 2007). The authors stated that although school based programmes in America have been the primary site for youth suicide prevention, few have been evaluated. This study had 4,133 participants in nine high schools in three states in America. Participants were randomly allocated to intervention and control groups. Self-completion questionnaires were completed by all participants three months after the programme had ended. Results showed that significantly lower rates of suicide attempts and greater knowledge about depression and suicide were evident in the intervention group.

2.5.2 Reviews

There have been several systematic reviews and scoping exercises undertaken in this general area over recent years. Of particular relevance is the EPPI Report (2002), which reports on a scoping review of the effectiveness of health promotion interventions aimed at suicide prevention in young men aged 19-34 years. Only a few studies

evaluating the effectiveness of suicide prevention interventions for young men (Guo & Harstall, 2002; Hilder, 1998; Ploeg *et al.*, 1996 & 1999) were identified. Ploeg *et al.* (1999), summarized the evidence about the effectiveness of school-based suicide prevention interventions, highlighted significant gender differences. They concluded that young men were more likely to experience harmful effects from interventions than young women and that there was insufficient evidence to support school-based suicide prevention interventions. Similarly, Guo and Harstall (2002) and Hilder (1998) concluded that there was uncertain and inconclusive evidence about suicide prevention programmes in schools.

A review undertaken by Beautrias *et al.* (2005) in New Zealand identified several major themes relevant to the prevention of suicide and suicide attempts. They stated that a range of *“social, personality, childhood and related factors make contributions to suicidal behaviours”* but that the largest contribution comes from mental health problems (p.46). Beautrias *et al.* (2005) concluded that suicide prevention strategies must include approaches that aim to improve the detection, treatment, management and prevention of mental health problems in the population. They singled out two approaches of particular potential: firstly, those interventions focused on the recognition, management and treatment of depression and, second, those programmes designed to address alcohol and substance misuse. They further advocated the provision of family support and early intervention programmes to prevent youth suicide. Early intervention was determined as targeting at-risk families and aiming to improve childhood exposure to family dysfunction and to promote educational and life opportunities for young people.

Leitner *et al.* (2008) undertook a systematic review focusing on the effectiveness of interventions to prevent suicide and suicidal behavior funded by the Scottish Executive Health Department (now Scottish Government) in 2005. The review did not focus exclusively on young men nor on Scotland alone. The authors noted methodological concerns about many of the identified studies, most of which were undertaken in the United States or Canada. However, studies from the United Kingdom accounted for 19% of primary empirical studies. The review showed that almost half (46%) of the

research evidence focuses on interventions for psychiatric populations, particularly focusing on people with depression or borderline personality disorders. Leitner *et al.* (2008) also pointed out that the most prominent focus of the literature was on pharmaceutical intervention and evaluations of such interventions show few indicators of positive impact.

The most recent published literature review of interventions for suicidal youth was published in 2009 (Daniel & Goldston, 2009). The review focused on published controlled studies of psychosocial treatment interventions for reducing adolescent suicidal behaviour and specifically on the developmental aspects of these interventions. The authors concluded that there was *“insufficient data available from controlled trials to recommend one intervention over another for the treatment of suicidal youth but interventions that are sensitive to the multiple developmental contexts have potential for greater effectiveness in reducing adolescent suicidal behaviour”* (p.252).

2.6 Summary

It is clear from this brief review of the literature that limited research was undertaken between 2000-2009 using a qualitative approach with regard to young men's experiences of suicide and their experiences of services while suicidal. In relation to young men's experiences of services, the published literature presents findings regarding the role of family and friends in support of young suicidal men, the need for ongoing training for General Practitioners and perceptions of 'needing help' and having confidence in the help and support available among young men themselves.

Chapter Three: Methodology

3.1 Introduction

An underpinning conceptualization of suicide as a multidimensional, complex phenomenon was reflected in the choice of a qualitative research design for this study. The fact that relatively little is known about young men's experiences of suicide further validated this qualitative approach (Green & Thorogood, 2009). The study aimed to uncover and understand the uniquely individual (but socially located) experience of suicide and this required adopting an approach capable of accessing these experiences in detail and in ways which reflected a participant (emic) perspective. Consequently, and notwithstanding the problems associated with the contextualised nature of interview data (Silverman, 2006), in-depth interviews were chosen as the means of data collection.

3.2 Preliminary work

3.2.1 Contact with stakeholders

Given the sensitivity of the research and the heavy reliance on health services to recruit young men, it was important to ensure that relevant stakeholders were made aware of the study and given the opportunity to have some input into decisions about its implementation. A significant amount of time and effort was invested in establishing and maintaining contact with a range of stakeholders. Such contact / stakeholders included:

- presentations to / meetings with relevant Trust committees and managers (e.g. the Southern HSS Trust, Research and Best Practice Committee / Belfast HSC Trust, Assistant Director, Mental Health and Learning Disability) as a means of informing them of the research and seeking their advice about a range of issues connected with local-level Trust implementation;
- presentations to / meetings with a range of statutory and non-statutory sector organisations (for example, regional and local-level counselling groups, the North and West Belfast HSS Trust Task Group on Suicide and Self-harm (comprised of

a wide range of stakeholders including, for example, members of families bereaved as a result of suicide, local clergy, charities and community and voluntary sector counselling support groups) and the North and West Belfast Health Action Zone. The need for such wide-ranging contact in the Southern HSC Trust area was removed as the Trust already had a Research and Best Practice Committee in place which brought together a wide range of statutory and voluntary/community sector organizations, and;

- presentations to / meetings with a range of clinicians working in both acute and community statutory mental health services – often these presentations were given to individual teams, for example, Community Mental Health teams, specifically targeted as crucial to the recruitment of relevant young men.

As a result of these meetings / presentations, a wide range of stakeholders ‘signed up’ to the research in principle, including in terms of enabling access to young suicidal men. Consequently, going into the active (recruitment) phase of the study, a necessary network of contacts as well as informed ‘goodwill’ to facilitate the research process had been established. This networking continued throughout the lifetime of the study, ensuring that its profile was kept high and a necessary channel through which to update stakeholders on study progress as well as seek advice on relevant issues was maintained.

3.2.2 Recruitment and training of clinical interviewers

In order to ensure the safety of participants as well as to facilitate a timely interval between their engagement in the study and the subsequent interview, a number of clinical (nurse) interviewers were recruited. The interviewers were all fully trained mental health nurses who, because of this, could be relied upon to monitor a young man’s emotional status throughout the entire interview process and be able to respond appropriately, including and especially if significant distress was detected. All interviewers were provided with additional comprehensive training to help support them in their role as research interviewers. This included the provision of information,

guidance and opportunities for practical experience. In addition, they each received a 'study pack' containing relevant practical material in order to prepare for, undertake and follow-up on the interviews. This pack included copies of the Participant Information Sheet and Consent Form (Appendix 1).

3.3 Inclusion / Exclusion criteria

Inclusion criteria were:

- male;
- aged 16–34 years;
- resident within the Southern Trust HSC and north / west Belfast area;
- experienced suicidal ideation/intent as assessed by Beck's Scale for Suicidal Ideation Worst (BSSI–W) (see section 3.6);
- clinically assessed as safe to participate in the research on at least one occasion prior to interview;
- willing and able to consent to and participate in the study.

Exclusion criteria were:

- female;
- aged under 15 or over 35 years old;
- resident outside the Southern Trust HSC and north / west Belfast areas;
- have no previous suicidal ideation/intent as assessed by Beck's Scale for Suicidal Ideation Worst (BSSI–W);
- clinically assessed as unsafe (i.e. emotionally unstable) to participate;
- unable to consent to and participate in the study.

3.4 Sample and Setting¹

As the research was required to produce knowledge relevant to the care of suicidal men aged 16-34 it was important to include a cross-section of such men, including those who had, as well as had not, engaged with services and from across the entire age range . We were interested in gaining insight into the broad scope of experiences and associated help seeking behavior of young suicidal men. Consequently, a purposive sample along two dimensions was obtained: (i) age range and (ii) contact/lack of contact with statutory and non-statutory mental health services. The final sampling frame targeted the following 'categories' of young suicidal men, defined primarily in relation to their (non) engagement with services.

Men aged 16-34 currently engaged with statutory mental health services: access was obtained through both the Belfast HSC Trust and Southern HSC Trust. A wide range of relevant acute and community adult and child mental health services were approached, including, for example: A&E departments; psychiatric liaison service; in-patient mental health; primary care; community mental health teams; secondary care, self harm team, and; child and adolescent mental health teams.

Men aged 16-34 previously engaged with statutory mental health services: access was to be obtained through both the Belfast HSC Trust and Southern HSC Trust. Only those men who had been engaged for at least two clinical sessions and who had disengaged prematurely (through, for example, failing to attend scheduled appointments on successive occasions) were to be included. Access to this group of young men was to be gained through Trust databases.

Men aged 16-34 currently using a range of non-statutory counselling organisations: access was obtained through a wide range of local-level community sector counselling organisations that dealt with suicidal young men in both the Belfast HSC Trust and Southern HSC Trust areas.

¹ Appendix 2 contains 'Flowcharts' providing detailed information on the extended process of entry into, participation and exit from the study relating to the four categories of young men.

Men aged 16-34 who had not had any contact with statutory or non-statutory mental health services: access was obtained through a comprehensive advertising campaign across a range of media including: local and regional radio; local and regional newspapers; distribution of posters, leaflets and /or contact cards to a diverse range of locations (Appendix 4). Young men who considered themselves to have been suicidal at some earlier point in their lives were invited to make contact with the research team using either email or telephone.

3.5 Recruitment

Men aged 16-34 currently engaged with statutory mental health services: In order to facilitate recruitment, participating clinicians were provided with a 'study pack' containing a range of information / guidance and other support material. Recruitment was initiated by an approach made by a clinician on the basis of his/her professional assessment of a young man's 'fitness to participate', that is, his ability to participate safely in the research. At this point, each young man was provided with the Participant Information Sheet (PIS) (Appendix 1). He was informed he could contact the research team should he wish to learn more about/consider his participation in the research. Once a young man had made contact, a period of at least 10 days then ensued to allow him time for further reflection. Thereafter, he was contacted by a designated member of the research team to discuss the research and his participation and, if appropriate, arrange a time, date and location for interview.

Men aged 16-34 previously engaged with statutory mental health services: Existing Trust databases were to be interrogated for the patient identifier numbers of relevant young men, along with the name and contact details of their GPs. A 'study pack' was then to be sent to each GP which included a range of information, guidance and practical material to facilitate recruitment. Thereafter, recruitment was to follow the process outlined above for '*Men aged 16-34 currently engaged with statutory mental health services*'. However, no young men were recruited in this category because of significant limitations in existing Trust databases. These meant that records pertaining

to young men resident in the geographical areas of interest who had disengaged from services were unavailable.

Men aged 16-34 currently using a range of non-statutory counselling organisations: In order to facilitate recruitment, participating counsellors were provided with a 'study pack' containing a range of information / guidance and other support material. Recruitment was initiated by an approach made by an appropriately trained counsellor on the basis of his/her professional assessment of a young man's 'fitness to participate', that is, their ability to participate safely in the research. Thereafter, recruitment followed the process outlined above for '*Men aged 16-34 currently engaged with statutory mental health services*'.

Men aged 16-34 who had not had any contact with statutory or non-statutory mental health services: This strand of recruitment was undertaken in an effort to reach those young men who had not availed of any type of statutory or non-statutory service and, as such, constituted a particularly 'hard-to-reach' population. Recruitment was pursued through a comprehensive advertising campaign in both the Southern and Belfast HSC Trust areas, which operated throughout the lifetime of the study. A diverse range of media were employed, including: interviews given by members of the research team to local and regional radio; advertisement (Appendix 3) placed in local and regional newspapers, and; distribution of posters, leaflets and /or contact cards (Appendix 4) to a wide range of locations, including, for example: GP surgeries, libraries, colleges of further education, universities and football clubs. The recruitment process involved either initial telephone or email contact on the basis of which a young man was provided with preliminary information about his anticipated role in the research. The PIS was posted/emailed to the young man at this point. Thereafter, recruitment followed the process outlined above for '*Men aged 16-34 currently engaged with statutory mental health services*'.

The following table sets out the actual recruitment achieved from each of the four categories of engagement. In addition, two new categories of engagement have been created to reflect: (a) the participation of young men previously engaged with statutory mental health services and who had been discharged on the basis of clinical assessment (as distinct from self discharge on the basis of dissatisfaction with services), and; (b) young men previously engaged with non-statutory (counselling) services. *All* young men with previous engagement of both statutory and non-statutory mental health services could, at the time of their participation in the study, have been engaged with their GP and/or taking medication related to ongoing mental health issues (e.g. depression/anxiety). Furthermore, the majority of young men had current or previous experience of *both* statutory and non-statutory services so that, in the following Table 1, individual participants appear in more than one column.

Table 1: Participant recruitment according to categories of engagement²

Currently engaged with statutory MHS ³	Previously engaged with statutory MHS (self discharge)	Currently using non-statutory MHS	No contact with any MHS / counselling	Previously engaged with statutory MHS (clinical discharge / service withdrawn)	Previously engaged with non-statutory MHS
Participant 2 Participant 5 Participant 7 Participant 9 Participant 20 Participant 22 Participant 31 Participant 51 Participant 52 Participant 57 Participant 62 Participant 67 Participant 69	Participant 4 Participant 6 Participant 10 Participant 43 Participant 46 Participant 62	Participant 2 Participant 6 Participant 9 Participant 13 Participant 19 Participant 20 Participant 22 Participant 32 Participant 57 Participant 67	Participant 1 Participant 12 Participant 14 Participant 17 Participant 42 Participant 59	Participant 3 Participant 13 Participant 26 Participant 28 Participant 29 Participant 32 Participant 39 Participant 73	Participant 10 Participant 25 Participant 51 Participant 54 Participant 63

² Numbers attached to participants do not run in sequence.

³ MHS = Mental health services

3.6 Assessment of suicidality

Given the need to be sure of the consistency and integrity of the population of young men engaged in the research, that is, that all young men had been actively suicidal at some stage in their lives on the basis of which they could talk about relevant experiences, the Beck Scale for Suicidal Ideation – Worst (BSSI-W) was employed. This is a well validated (Beck *et al.*, 1997; Beck *et al.*, 1999) tool for assessing suicidal intent at its worst, irrespective of time elapsed since. It has been used extensively in suicide related research.

The scale was administered to participants by the clinical interviewers at the end of their interview. No classification of scores in terms of severity of suicidal ideation is provided; however, splitting the score range into 4 equal components provides an arbitrary classification of mild, moderate, severe and profound suicidality. Allocation of participants' scores according to this classification is represented in Figure 1. All participants scored as having significant suicidal ideation, with 85% scoring as having severe to profound suicidal ideation. This assured the team that the population of young men engaged in the study was valid in terms of contributing meaningful data to answer the research questions.

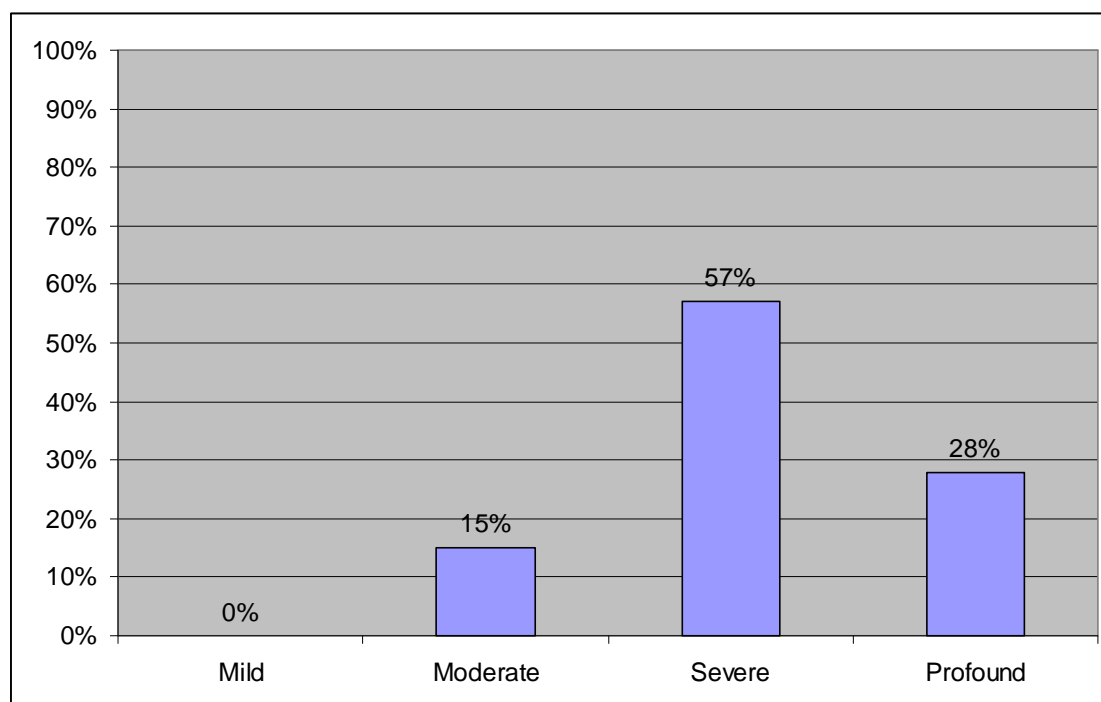


Figure 1: Total BSSI-W score frequencies of participants

3.7 Data Collection

3.7.1 Introduction

In keeping with a qualitative research design, no *a-priori* limits were set on the number of interviews required for the study. However, the research team's previous experience of qualitative studies, along with the evidence regarding sample sizes in studies with similar designs and/or aims and objectives (Cleary, 2005; Cutcliffe *et al.*, 2006; Sun *et al.*, 2005) indicated that something in the order of 40 participants would provide a robust data set. A total of 36 young men were subsequently recruited into the study. The interviews conducted with them were overwhelmingly constructive. This was both in terms of delivering high quality data on the experiences of young suicidal men as well as from the perspective of the young men themselves who routinely informed the clinical interviewers of the 'positive' nature of their participation.

3.7.2 Organisation of interviews

The procedure for organising an interview was the same irrespective of the means through which young men were recruited into the study, that is:

- once the designated research team member had confirmed a young man's intention to participate in the research, s/he⁴ organised a date, time and location of interview with him;
- s/he then contacted one of the pool of clinical interviewers in order to ascertain his⁵ availability to undertake the interview according to the young man's preferences;
- the above step was repeated as necessary;
- a designated representative of the organisation in whose premises the interview was due to take place was then contacted to make sure that the date and time were suitable;
- once a clinical interviewer's availability, as well as the chosen location, were verified, the young man was contacted once again to confirm the interview arrangements.

3.7.3 Location of interviews

Two main requirements informed the choice of locations for interviews: privacy and 'safety' for both the interviewee and interviewer. A number of suitable locations were identified in statutory and community sector services. Essentially, these were quiet and private rooms set within premises that either housed or were close to trained (mental) health care personnel to provide 'emergency' support if necessary. A representative from each of these services was identified to act as the designated liaison person with whom all discussion concerning the organisation of the interviews could be conducted.

⁴ Due to maternity leave, the member of the research team with designated responsibility for organising interviews switched from a female to a male and back to (the same) female again.

⁵ All of the clinical interviewers were male.

3.7.4 Assessment of 'fitness to participate'

All participating young men were independently assessed for 'fitness to participate' by the clinical interviewers as a preliminary step to the conduct of interviews. In addition, clinical interviewers continued to monitor participants throughout the entire interview. Had any young man been assessed as unfit to participate at any point during the interview process, he would have been informed immediately, the interview terminated and he would have been referred to relevant services.

3.7.5 Obtaining informed consent

In addition to the information and opportunities for reflection, provided at strategic points in the recruitment process, informed consent was obtained as follows:

- immediately prior to the interview commencing, each young man was provided with a copy of the PIS and asked to take the opportunity to read through it and ask questions. Moreover, he was reminded of his right to terminate the interview at any time, without providing any reason and with no adverse consequences. Once his wish to participate had been confirmed (no participant chose to exit the study at this stage) he was asked to sign the Consent Form (Appendix 1) and, thereafter, to undertake an interview;
- a young man's signature on the Consent Form was taken to indicate that informed consent had been obtained;
- two copies of the Consent Form were signed by both the young man and the clinical interviewer (one retained by each).

3.7.6 Conduct of interviews

Data were collected by means of a semi-structured interview. All interviews were audio-recorded, with permission. The duration of interviews ranged from 45 minutes to just under two hours. Interviews began with an opening 'exploration' question which asked the participant something like 'Could we just start by telling me about your experiences of being suicidal?'. This question was designed to open up the interview so that it took the form of a discussion between the interviewer and the interviewee, as distinct from a

‘question- and-answer’ session. Thereafter, a series of open-ended questions sought to enable the young man to continue to talk about his experiences in terms of what he considered to be meaningful to his own suicidality. Whilst the nature and focus of questions were determined primarily by the ongoing and unfolding discussion between the interviewer and the participant, a limited number of pre-specified issues were introduced. These included: a question addressing the support, including in terms of accessing formal and/or informal (mental) health care services, which a participant had sought/accessed, and; a question addressing the factors that had helped and continued to help maintain his wish to stay alive. Where appropriate, some gentle ‘probing’ (e.g. ‘Could you tell me a bit more about that?’) allowed the interviewer to ensure that a topic of interest was adequately explored.

3.7.7 Administration of BSSI-W

The BSSI-W was administered after the main body of the interview had been completed. Clinical interviewers read out statements associated with the 21 items included in the questionnaire and asked participants to rate these statements verbally. Responses were then hand written on the questionnaire.

3.8 Data Analysis

The aim was to provide an analysis with *explanatory* value in terms of understanding suicidal behavior amongst young men. That is, we were aiming to identify patterns and relationships within the data that would offer suggestions concerning how care and services could be developed appropriately. Consequently, we wanted to move beyond the mere description of recurrent or common ‘themes’ observable in the interview data to offer an analysis that explored the context of and relationships between these themes (and their constituent ‘properties’ and associated concepts). This offered a means of thinking about a range of relevant issues to do with the provision of care to young suicidal men.

Data analysis was as follows. After initial verbatim transcription, Glaser and Strauss’ (1967) process of open coding was applied to each interview transcript. That is, the text

was examined line by line in order to identify and subsequently 'code' processes in the data. Such a process of 'substantive coding' codified the substance of the data, frequently using participant's own words. Following this initial coding, individual labels (that is, codes) were compared with each other in order to develop clusters or categories of codes according to obvious fit. This allowed a tentative conceptual framework to be developed, comprising a number of categories (with associated labels). This latter process was accomplished by examining common themes and/or concepts evident in each of the categories or, alternatively, by identifying if there was a process or theme underpinning several of the categories that would allow them to be grouped together. This framework was subsequently confirmed by further, conceptually-led reduction of the data. Here, the tentative categories were gradually grouped together under 'umbrella terms' by examining all the categories to identify how they clustered or connected. Each of these umbrella terms thus encompassed several initial tentative categories. This extended process gradually enabled the development of a number of core categories (see below, Chapter 4, Findings), which encompassed the entire dataset and captured the essential processes evident in the data.

The following procedures and processes were followed in order to enhance the validity and reliability of data analysis (Silverman, 2006). In terms of reliability: (i) all interviewers were trained with a view to establishing consistency in the conduct of interviews; (ii) all digital recordings were transcribed verbatim, and; (iii) transcripts were distributed amongst the research team for individual analyses, which were then shared in order to promote the full possibilities for analytical insight. In terms of validity: (i) comprehensive data treatment meant that all data were analysed and accounted for, and; (ii) constant comparison ensured that the final analytical framework was incrementally built up through comparison both within and across interview datasets.

3.9 Support for participants

Participants were provided with travel and subsistence expenses and were given a card containing a wide-ranging list of local-level support organisations capable of providing help and support should they require this subsequent to the interview. In order to help ensure that no young man was detrimentally affected by his participation in the research, all participants were offered the opportunity to avail of up to six sessions of counselling from a qualified and highly experienced counsellor at no cost to themselves.

3.10 Post research activity

Subsequent to the conclusion of the study, all participants were sent a letter thanking them for their participation in the study. All services / organisations which had been sent posters etc. advertising the research were written to and asked to remove all relevant material. A number of follow-up visits to these locations were undertaken as a means of further ensuring the removal of adverts etc.; during these visits no such material was found. However, two young men did contact the research team after the study had formally closed with a view to participation, both of whom provided the name of the service/organisation in which they had seen the poster. These locations were subsequently contacted and asked to remove all advertising material.

3.11 Ethics / research governance

The study adhered to all relevant research governance requirements. It received full Office of Research Ethics Committee, Northern Ireland (ORECNI) approval (REC Reference: 06/NIR02/149). In addition, it complied with the research governance requirements of both the Belfast and Southern HSC Trusts.

Chapter 4: Findings

4.1 Introduction

This chapter provides a detailed description and explanation of the services required by suicidal young men in Northern Ireland, according to the data provided by the participants in this study. Furthermore, limitations with the current mental health care services are highlighted and the specific qualities, interventions and activities that mental health practitioners (MHPs) need to possess and/or provide in order to provide meaningful, effective care to suicidal young men are identified. The chapter continues with a detailed description and explanation of the interventions and activities that the young men highlighted as being therapeutic in helping them, in the initial stages, to begin the process of recovering from suicidality. The chapter then concludes with a detailed description and explanation of the ongoing, longer term work that is required in order for young men to recover from suicide, and what might be provided to help them on this potentially protracted journey of recovery.

Recognising that any process, including the process of recovery from suicide, occurs over time and, according to Glaser (1978; 2001), will have distinct phases, this chapter captures three such phases, which represent the ‘core categories⁶’ of the findings. The first core category (phase one) is termed *Widening Access and Bolstering Pro-active Outreach*, the second (phase two) *On becoming a man...*, and the third (phase three) *Equipping young men for the challenges of 21st century living*. Together, these three stages collectively answer the two original research questions:

How can mental health care services be most appropriately configured to encourage their use by suicidal men aged 16-34?

What is the required response of mental health care services for suicidal men, aged 16-34?

⁶ The term ‘key themes’ could work equally well here. In terms of method, strictly speaking, a core variable is the highest level conceptual element of a (modified) grounded theory (Glaser and Strauss, 1967) and while we drew heavily on grounded theory methodology to conduct this research, we do not claim that this is a grounded theory study.

Throughout the chapter a detailed explanation of the development and composition of the core categories is provided by highlighting the initial categories that were induced from the data. These initial categories are evidenced and illustrated by drawing on direct quotes from participants. As indicated in Chapter 3, the young men who participated in the study gave extremely eloquent and insightful accounts of their suicidal feelings and behaviour, including in relation to their experiences of services. Consequently, the extracts/quotes provided below only a flavor of those that, save for limitations of space, would have been included. In order to help understand the construction and development of the findings, the relationship between initial and core categories is depicted in Figures 2, 3 and 4.

4.2. Core Category and Phase One: Widening Access and Bolstering Pro-Active Outreach

This core category is comprised of four initial categories:

- Encountering pro-active suicide prevention programmes;
- Having access to community-based, effective (and informal) suicide support centres;
- Encountering mental health practitioners (MHPs) who possess and convey therapeutic and supportive (non-judgemental) attitudes;
- Re-connecting the person with humanity.

Essentially, the core category is concerned with current formal mental health services and such related systems as mechanisms/processes of referral. From the point of view of study participants, these services were rarely congruent with and appropriate for suicidal young men. More especially, data provided by participants indicated that the type, nature, and geographical location of formal health services (even when they could get access) offered, at best, only limited help to address their suicidal thoughts, feelings and behaviour. Concomitantly, data suggested that suicidal young men required and wanted different types/forms of services and importantly, that there was a significant, clear need for more 'pro-active', 'outreach', suicide prevention services in addition to /

distinct from responsive or reactive suicide services. In keeping with such a development, according to the data, was the parallel need for increasing awareness in the community of the existence of such services. Paradoxically, the advertising and placement of these services would somehow have to be discrete. This would help ensure they were used by young men in the face of their awareness of the widespread stigma associated with suicidal help-seeking behavior.

Further, the data highlighted how any such 'advertising' of services, or any 'media-based' outreach attempts would benefit from being geared towards the nuances of the generation that they would be trying to reach. In other words, in addition to 'traditional' efforts, such attempts might make use of technology more suited (and common) to the age group of young men who were the focus of the study. Ergo, significant use of the internet, 'text messaging', email, social networking and even 'You-Tube' might be considered.

Well most of the website or support groups I know of that people would generally use on the internet are, well "Recover your life" would be funded by donation and people that work for it has come out of their own pockets. Ourselves, our Bebo group itself would be free to set up and then the support things on ours, like money wise we would get from the Foundation so that's government and we're not going into that. (*Interview 32*)

In addition to more pro-active, preventative suicide 'outreach' programmes, data provided by the participants indicated that there would be utility and value in creating (more) community-based and relatively informal 'drop-in' suicide centres. These could be located in epidemiologically-informed suicide 'hot spots' and/or communities with documented higher rates of suicide. The issue of providing adequate and appropriate services for young suicidal men in Northern Ireland does not occur in a 'cultural-vacuum' or decontextualised life. Study participants discussed their perceptions of how suicide is viewed in Northern Irish society and referred to the stigma typically associated with someone who used suicide-related services.

So there needs to be somewhere where people, young people can actually trust people, somewhere they can go – like a local place, there's a wee place on the Falls Road which I think is marvellous...it's been set up and....but people will not want to walk into there because everyone knows it's the suicidal man's group. (*Interview 10*)

... Probably not [use services], again, attached with the whole stigma of looking for the help, that's the big thing. To be honest with you, I would say no. (*Interview 73*)

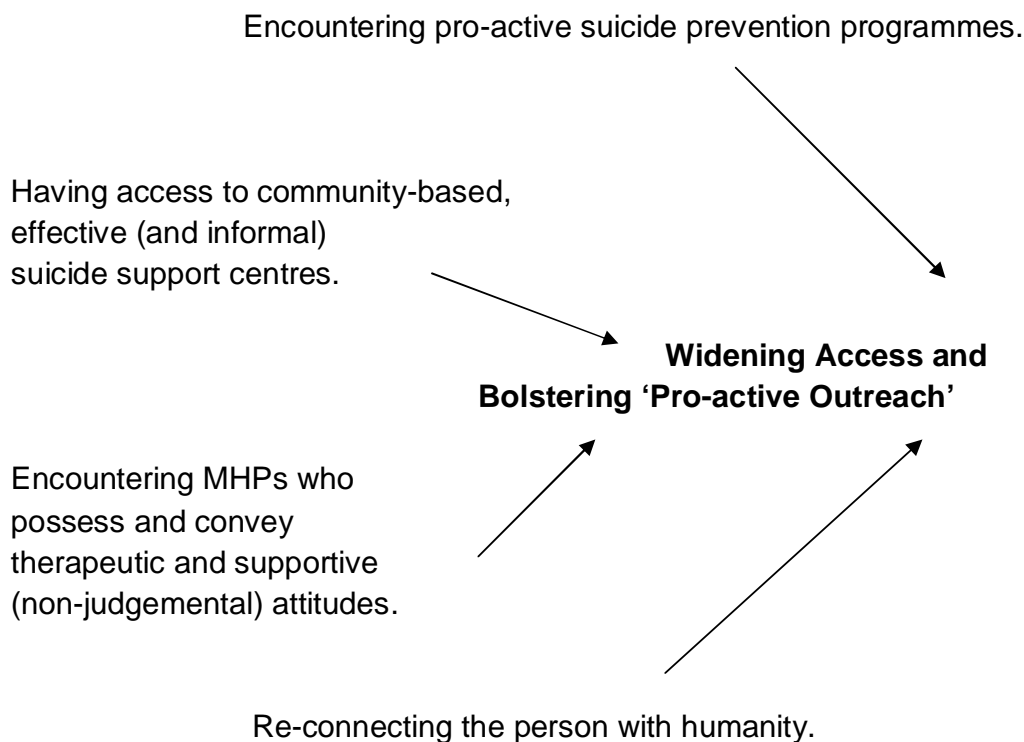
Accordingly, eradicating stigmatised views might be implausible (though the authors continue to argue that serious and sustained attempts still need to be made). A more pragmatic solution to encourage young men to make contact with services to help them address their suicidality would be to create additional, less-'stigmatising' services.

This core category is also concerned with the types of people that young men hope to encounter when they come into contact with services to help them with their suicidality. Perhaps more accurately, it is concerned with the particular qualities and skills that young suicidal men found helpful in people with whom they worked. Especially in relation to the initial stage of the process of recovery, it should not be understated how much emphasis the young suicidal men placed on such qualities and skills. These qualities were the principal 'interventions' that the Mental Health Practitioners (MHP) made use of. Therapeutic closeness and firm interpersonal connection between them and the practitioner not only served as the platform upon which all future interventions were built but was made possible because of the practitioner possessing and communicating certain attitudes.

This core category is also concerned with initial attempts to combat the pervasive sense of disconnection referred to by the young men in the study. Their accounts indicated that having a sense that they mattered, that someone else was concerned about and interested in them, was immensely important and had a specific countering effect on their suicidal ideation and perspectives. Feeling cared about created the perspective for the young men that they were no longer alone. The therapeutic value of such a sense or perspective in the context of providing care for suicidal young men should not be

underestimated. Being disconnected from humanity could be directly countered by this connecting with their mental health practitioner.

Figure 2: Core Category and Phase One: Widening Access and Bolstering Pro-active Outreach



4.2.1 Initial Category One: Encountering pro-active suicide prevention programmes

This category is concerned with the support, creation and expansion of (for want of a better term) pro-active, outreach programmes for the suicidal young men. The problems associated with referral systems were raised and acknowledged by participants as a barrier to accessing services. For some, it was abundantly clear that the configuration and organisation of formal mental health care actually served to discourage young men from attending/accessing such services. Analysis of the data provided by participants and subsequent conceptualisation of this material repeatedly indicated how they felt there was a need for greater outreach and better 'advertising' of the services that

already existed. Thus, the young men described how they did not hear (quickly enough) about the suicide prevention services that existed and, for most part, when they did find out, it was after they had made a suicide attempt.

And you don't realise there's other possibilities out there. There are support groups, but you don't hear about them. (*Interview 59*)

I suppose everyone thinks you would have to rely on the person coming forward themselves, but also in another sense you know looking for the indicators as such, you know just spotting the signs and trying to get in there whenever you know like if you see someone that has been a patient of that, you know you get in and you ask them and reassure them that, you know, it's okay in order to tell them what the score is. (*Interview 46*)

Moreover, the referral mechanisms and processes operating within current formal mental health services were perceived to actually create a barrier to access. There was a sense of the following: if the young person did not meet pre-determined criteria (e.g. have an assigned social worker / e.g. have been diagnosed with a mental health condition), then they could not be referred and thus could not access services. These 'barriers' to access serve to underscore the need for pro-active outreach as well as discrete community 'drop in' centres (see below, Initial Category (2)).

But whenever I started to look for it, it was really quite hard to access some of it, because either you had to be hospitalised and I hadn't been hospitalised, you either had to have a letter of referral from a social worker, and I didn't want a social worker anywhere near me. (*Interview 57*)

The only thing I ever remember after here was that it took six months for me to actually get an interview with a psychiatrist in this hospital, which to me was six months down the line which things had drastically changed. (*Interview 63*)

Outreach programmes of a variety of forms and styles were described as a much needed additional suicide prevention resources. Examples of such outreach initiatives included (but should not be seen as limited to): literature for general as well as targeted distribution, posters, educational programs (in schools, for example) as well as other forms of community level programs (in youth clubs, colleges of further education, for example), sometimes involving testimony from people who had made a previous

attempt on their life. Having outreach through 'text messaging' and on the internet was seen as a viable approach, perhaps more congruent with current patterns of interaction/communication amongst young people generally. Other forms of outreach suicide prevention measures included: media (for example, radio and TV) representations and portrayals of suicide and suicidal people as well as adverts placed in literature that specifically targeted young males. It is interesting to note that these ideas are entirely in keeping with proposals for addressing the high rate of suicide in the UK National Suicide Prevention Policy as well as other national suicide prevention strategies (see Chapter Five: Discussion).

To get in when they are in primary school, and the first form years, the first to third year maybe in secondary ... We have, we set up five-a-side football teams, we do cross community work, and try and get them interested and this is why we do it, you know. Here are some of the ...almost...take away from it being the "we're only here when you feel like this. We know at some point you may go this way, here's how we can stop you going down the line" because they're almost in after the event, the agency, as opposed to a preventative. You know, let's nip it in the bud before it gets worse, and I think you need to change how we deal with it. (*Interview 59*)

Now I must say, there's been a television campaign, the advertising, and to be honest, I find them quite counterproductive, because I thought, had I been sitting there in my state of mind, I wouldn't have went near that, simply because of the way it was portrayed. ... I think it would have been better showing [him] out having a lot of fun and a good time with his friend, you see that in one of them, but a majority of them, it's just – I just don't think – I suppose the like of me referred myself. I don't think it accurately portrays how you feel. (*Interview 59*)

Inevitably, the possibilities for the full range and composition of pro-active outreach programmes/services and the nature of the care and support provided through their auspices were not exhausted in the accounts provided by the young men. However, they were clear that what is currently available was insufficient and that services are required which are:

- a) more proliferate;
- b) based in the community;
- c) be discrete yet full of effective services, and;
- d) have a high degree of informality.

Without going through the whole rigmarole of A&E, the whole rigmarole of that big attachment to the whole health service, if you like, because you have to go through so many teams just to get some sort of answer, if you like. (*Interview 73*)

This is a more civilised way of doing that there, because like it was the weekends, you didn't have the hospital part open but then people from home team would phone me in the evenings and meet me in the mornings. ... I think they were actually from St Luke's itself but I'm not a hundred percent sure on that ... I can't actually remember. But you know I prefer doing it that way than being locked up for the weekend. (*Interview 32*)

And I went to [name of hospital] for a while ... as an inpatient, and I went there for a while and they....I didn't see them as any help at all, they didn't talk to me, they didn't wonder what was going on, they weren't informal enough important. ... Yeah, yeah....from all....from the start whenever they were asking why are you doing it and stuff - I sort of felt like they were blaming me....everything that has happened to me is all my fault was sort of the feedback I was getting from them ones and I sort of thought, do you know they could be a wee bit more helpful. (*Interview 4*)

There are important processes here that are clearly part of the encompassing processes of **'Widening access and bolstering pro-active outreach'**. Conceptually, the data indicated that current services were either insufficient and/or inappropriate and what was needed was a major conceptual shift in how suicide prevention services were viewed (and thus provided) for young men. It seems that a further disconnect in the lives of young men is in the nature and distribution of the services that currently exist 'versus' the nature and distribution of the services that they feel they need. At least in part, this disconnect might account for some of the significant rise in the rate of suicide for this population in Northern Ireland today.

Accordingly, while most formal suicide focused mental health services tend to be of a 'reactionary' (secondary prevention) nature, what the young men described as being valuable was more 'pro-active' in nature. They favoured outreach programmes (as per the variety of forms outlined above) that should theoretically 'reach' more young men before they make a serious attempt on their lives, rather than waiting and responding to

a young man after he has made an attempt. Interestingly, rather than being such a radical idea, examination of such 'health promotion-esque' services in other parts of the world and in related mental health problem areas (e.g. addictions), shows that extant examples of analogous services can be located. For example, there are obvious parallels here with other community based outreach programmes such as: drug abstinence/education programmes (see, for example, Ball State University Outreach Programmes; drink driving outreach programmes (see, for example the Mother's Against Drink Driving (MADD) programme, 2010), tobacco avoidance programmes (Tobaccofree.org, 2010), and HIV/sex education programmes (see, for example, Latkin *et al.*, 2003)).

4.2.2 Initial Category Two: Having access to community-based, effective and informal suicide support centres

This category is concerned with the suicidal young men having access to community-based, effective and informal suicide support centres. Analysis of the data provided by participants confirmed their awareness of current formal mental health services as insufficient and/or inappropriate for addressing their suicidality. While there were 'pockets' of good practice that some of the young men had encountered, they believed that much could be done to improve current services.

Inextricably linked to the problem of having adequate and appropriate services was the issue of how they felt suicide was viewed in society, particularly the stigma associated with someone who used suicide-related services. As a result, participants clearly articulated the need for a different type(s) of service(s). For example, informality was valued far more highly than the approach to care they encountered, typically, within formal services. Partly premised on this preference for relatively informal, open-access support, the young men repeatedly gave statements regarding the need for some form of 'Drop In' centres in the community. There was something of a paradox in the data pertaining to this issue as the need for *discrete* community-based drop-in services was highlighted yet, at the same time, the problem of not being aware of and/or not knowing that these services existed at all was also raised.

The creation of (or extension of) community 'drop in' centres was the form of outreach service which received the most prominent support amongst participants. While they did not go into the detail of the care that could/should be provided within such drop-in centres, there was a strong sense that this form of suicide prevention service should be specifically geared towards young men. There was an emphasis on opportunities for social interaction and the generally 'laid-back' environment such centres afforded.

Well the best thing that happened to me, the best thing that I think saved me from everything was WAVE.....WAVE Trauma Centre up there in the Antrim Road there. ... you can go to WAVE at any time you want. ... But through WAVE like they.....I would know about all these different counsellors and all ... I wouldn't have seen a counsellor at all beforehand. ... And I started seeing a counsellor over there, I thought to myself – this is good, this is doing me good here, so I never missed it, I travelled from Gleneavy into Belfast once a week. I used to go in once a week, Jesus, sometimes a couple or three times a week, just to get out of the house and go down and play darts. (*Interview 10*)

It would be fantastic if there was a clinic for people who suffer from mental health. But if it was in a hospital, or a shopping centre, or somewhere that they could just go and say this is what's wrong, how can you help me, and that's what I would love to see happening, because at different times whenever I would have been looking for help, sometimes I got so fed up and frustrated, I got more depressed, and it was like the Catch 22 situation. (*Interview 57*)

4.2.3 Initial Category Three: Encountering mental health practitioners who possess and convey therapeutic and supportive (non judgemental) attitudes

This category is concerned with the suicidal young men having access to and encountering MHPs who possess and communicate helpful, therapeutic and supportive attitudes. Analysis of the data provided by the participants and subsequent conceptualisation of this material confirmed how some MHPs working with the young men possessed and communicated specific attitudes, qualities and demeanors. These qualities were the principal 'interventions' that the MHPs made use of, whereby they were 'present', holistically, with the participant.

The category is also concerned with the process of building a therapeutic closeness and firm interpersonal connection between the suicidal young man and the MHP. This

occurs (at least in part) as a result of the MHP possessing/communicating certain attitudes. This relationship is located in a 'professional' context, yet is most often manifested as a form of 'friendship'. As a result the participants in this study referred to the development of a 'professional friendship'. The 'natural' or 'normalness' of the MHPs, rather than 'stuffy' formality was clear and, indeed, welcomed by them. However, at the same time, the MHPs' professional experience and competence was a source of comfort and reassurance and helped the development of trust within an encompassing therapeutically effective relationship.

I found the reaction of the community psychiatric nursing staff to be dead on, saying "You're a good fellow and all – you shouldn't be doing stuff like that". ... Befriending, that's it. I would describe generally the support systems that have been available to me as dead on. Primarily through the CPN. He's ...aw...thumbs up. He's a lot of...experience in the field, he has. ... My CPN has a good understanding of me and my needs. Yeah. I wouldn't move one day, and he just said, "Come on we'll go for a walk!" and he took me on a two mile walk and came back and I was all...chilled out. (*Interview 54*)

I'm seeing a community psychiatric nurse ahhh, that's excellent as well. I would just go into him and talk about the week's issues and he would say, how are you feeling and anything on your mind, and like of all the things we've been speaking about lately. ... Ahhh, I would say that someone you can relate yourself to....like the people I'm dealing with today, especially in the CPN, I don't class them any higher or any lower than myself and he doesn't class me any higher or lower than himself. Someone that you can really relate to. (*Interview 2*)

In no order of priority the qualities that, according to the data provided by the participants, need to be present in MHPs in order for them to be able to provide effective care to suicidal young men are:

- a) A non-judgemental attitude; to be able to demonstrate respect for the person;
- b) A willingness to understand the suicidal person's view of the world;
- c) A willingness to form an inter-personal connection with the suicidal person, to connect with them;
- d) The ability and willingness to listen, to demonstrate that they are trustworthy;
- e) The desire to be supportive, and;

- f) The willingness to demonstrate a genuine sense of care and concern for the holistic well-being of the suicidal person.

Honestly? He listened to me. He heard what I was saying, and said “you’re having a really rough time son” and I went “yes, I am” and he went “no problem, that’s not good then.” ... There’s no judging. There’s no-one turning and saying “well you done this, or that, or the other.” (*Interview 69*)

I would need to be assured of their confidence. Trust, you’ve had to trust the person...100% like, because you are laying down all your weaknesses and all your fears and you have to trust the person. (*Interview 14*)

The counsellor was coming out and she was telling me, “How are you feeling?” and... It was making me aware of my feelings, making me aware of why I was feeling that way, and she was doing different wee exercises with me... Like, the way I was feeling, she could understand the way I was feeling, if you like, whereas anyone that was around me couldn’t because they didn’t. (*Interview 73*)

Participants referred to the importance of a sense of mutual respect that needed to be present, typically manifested through treating the suicidal young man like an adult, an individual, not ‘talking down’ to them. The young men also spoke of processes involved in creating and developing a sense of trust, including the value of genuinely listening on the part of the MHP. Lastly, and crucially, much of the sense of trust and familiarity was achieved by, not so much what the MHP did or said, but by the way they said it. The MHPs’ demeanor and attitude were described as being vital to the development of trust and a sense of familiarity. This demeanor was, again, personified by demonstrating humanness, warmth, understanding, empathy, approachability, a non-judgemental attitude, and care.

I get the feeling that she [counsellor] cares. And others don’t. Not everyone can care about everyone else. (*Interview 20*)

Well, I went in to her and I just explained about my whole history and my whole feelings and my suicide attempts, the abusing substances, all the rest of it and she says, right you’ve come to the right place...She doesn’t talk to me like a doctor she goes, like....you mess me about and I’ll mess you about and things like this. I can be completely honest with her... (*Interview 2*)

So I wanted desperately to tell someone else, someone who knew...who wouldn't judge me, who wouldn't... And in that confidential relationship ...it worked immensely actually. I thought it regained my... [self esteem]. (*Interview 5*)

There are important processes here that are clearly part of the 'larger' processes of **'Widening Access and Bolstering Pro-active Outreach'**. Participants in this study referred to their fear, previous experience of and current concerns about being judged. They also referred to the sense of stigma that they perceived in their communities. Members of society, including family members, had in the past judged them; some also spoke of how they judged themselves. Rightly or wrongly, these perceptions (and expectations) about being judged were projected onto the mental health services and those MHPs working within them. When the young men's expectations were 'challenged' or 'discredited' by encountering MHPs who did not communicate judgemental views/attitudes, they found this very helpful; it encouraged them to say more and to stay engaged with the mental health services.

Furthermore, the young men's pervasive sense of disconnection from humanity and their perception that 'nobody cares' were challenged or discredited when they encountered practitioners who were able to demonstrate a genuine sense of care about and commitment to a young man and his circumstances. For practitioners to be willing and able to listen intently to a young man's story, to attempt to see the world 'through his eyes' and to be manifestly supportive, were very powerful therapeutic act(s). According to the participants in this study this was just what they wanted/needed. Widening access, then, in this sense refers to widening access to the (for want of a better term) 'the right kind of practitioner'. Increasing access to what is currently available would only have limited value, given the experiences of participants who encountered current (or recent) services and found them to be lacking.

4.2.4 Initial Category Four: Re-connecting the person with humanity

This category is concerned with initial attempts to combat the pervasive sense of disconnection referred to by the young men in this study. In so doing, MHPs need to facilitate a re-connection with humanity. This is achieved by means of a number of processes that, together, work to communicate a sense of care as well as that the individual young man matters. Data provided by the participants and subsequent conceptualisation of this material repeatedly indicated how, for the young suicidal men in this study, having a sense that they mattered, that others were concerned about and interested in them, was immensely important. This had a distinct countering effect on their suicidal ideation and perspectives. Feeling cared about and that they mattered in the world created the perspective for the young men that they were no longer alone.

And, I think a large part of me died and I think what died within me was my ability to communicate and my ability to feel normal and my ability to adapt.....with, as I went on and grew older, grew up to adapt into the same types of maturing stages that other teenager, for example would have been going through at that time; I couldn't relate, I withdrew. (*Interview 9*)

For me it's just hopelessness, you feel hopeless, you feel very vulnerable, ammm you can't carry out your day to day activities because to the same confidence or degree you could have done in the past, ammm it's almost....the only way I could describe it is it's like a grey cloud constantly around you, everything looks grey, everything feels grey. (*Interview 25*)

The therapeutic value of such a sense or perspective should not be underestimated. The sense of being disconnected from humanity was directly countered by this connecting with a MHP. Participants made clear references to the feelings that were stimulated when they experienced another person (in the guise of their MHP) demonstrating an interest in them and their well-being. They were aware that they needed to feel that they mattered; they needed to feel that someone cared about them, and they were also very clear that, at times, they received such confirmation and validation from the MHPs with whom they came in contact.

I couldn't go to nobody or turn to nobody, and then I just didn't want to be there no more. ... And not knowing what to do and nowhere to go. ... It's always the...you know, you're useless, and why is it happening to me, and em...you know, why will nobody help you, and why can they not see what is going on. It's all things like that, and then just tell you you're worthless and what's the point anymore. ... So anytime, you know, that I feel I'm going down at all, I can phone him, and he'll talk to me and calm me like. ... They need to talk. I think that's the most important. If I didn't, I know I wouldn't be here like. (*Interview 39*)

The value of compassion and understanding, engaging with someone who was prepared to listen to them and manifestly interested in their well-being was made clear by participants. These 'fresh' and therapeutic experiences of feeling cared about, feeling that they mattered, feeling connected, all occurred in a very specific interpersonal atmosphere, one that was exemplified by the presence and influence of human warmth and engagement. Further, these experiences were directly opposite to their 'felt sense', namely – that they did not matter, that nobody cared about them, that it would not make a difference whether they lived or died. Additionally, it is important, though perhaps somewhat obvious to point out that the presence of these qualities and feelings in the MHP (e.g. care and concern for the client's as well as understanding) was not enough. The qualities and feelings also had to be communicated.

I would open up. That's it, I would not....like no disrespect to yourself, but a doctor sitting in a suit with glasses at the end of his nose like!!! My CPN, I would go in and sit with my CPN and he'd be sitting there in jeans and trainers. Like after a first few sessions with him, and.....I have a passion for fishing and he told me he was...loved fishing as well, so now once a month we would go fishing and have our session together. And just sit like two mates and...in a fairly close relationship. (*Interview 2*)

What they did for me that was so good...Well what they did was, they took me in and they immediately identified...the person that I was counseled by was a counsellor called [name of counsellor] and what that counsellor did for me, she reflected in her body language that she understood exactly what I was talking about. I felt for the first time that someone understood what I was talking about. (*Interview 9*)

In essence, this category is concerned with facilitating the young man's re-connection with humanity in the first instance by connecting with the mental health practitioner. This

re-connection with humanity is brought about by feeling cared about and valued; experiencing this sense and process of 'co-presencing'. Through demonstrating care, compassion, and interest, the MHP becomes the first point of re-connection with humanity; the young man connects with the MHP and thus begins to re-connect with humanity. In essence, this process shows how the mental health practitioner can/could become a 'representative' or 'emissary' for humanity. When a young man experienced this sense of being cared about by the MHP, the latter were, at the same time, communicating that at least one 'part' of humanity still cared about him. Engaging with the mental health practitioner in this way allowed young men to begin to internalise that they could still engage with humanity. The mental health workers' attitudes, demeanor and behavior provide an 'in road', an opportunity to re-connect.

You become antisocial. Withdrawn. People would say "Why didn't you talk to someone" or "Why didn't you confide in someone" or whatever. But you don't even feel like saying "hello" to people, let alone sitting down with someone and saying "I'm really not well and I'm really don't want to live anymore" ... That relationship [with the CPN], as it unfolded for me, between the two of us, was very meaningful. (*Interview 67*)

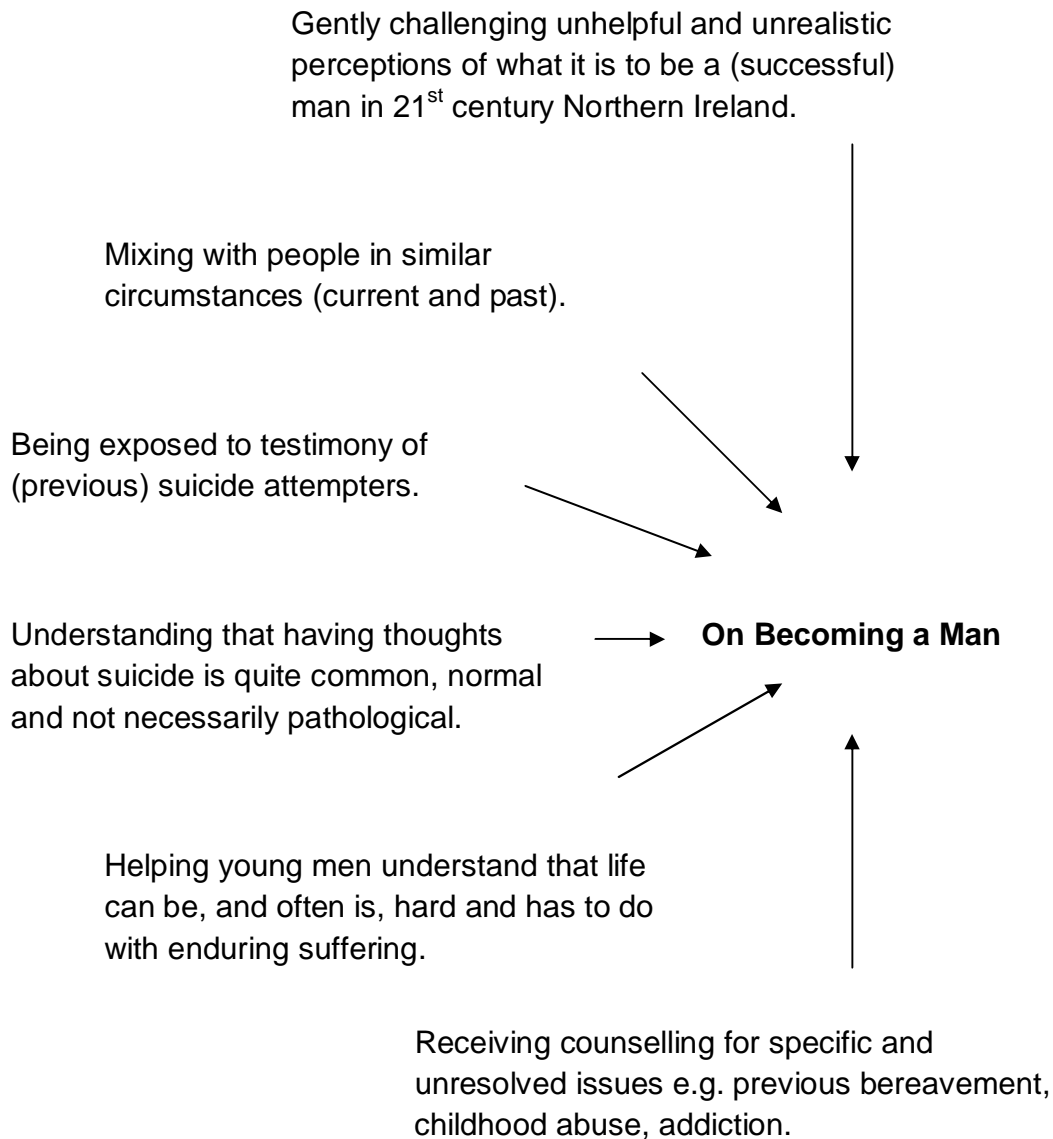
The data provided by the participants in this study indicate that the young men felt more connected to and/or engaged with other people when their basic interpersonal needs were met. These basic needs are met by the mental health worker possessing (or adopting) and communicating: a sense of warmth for the person; care for the person; compassion for the person's situation and experience; a sense of hope and hopefulness for the person's future; acceptance and tolerance; empathy; validation and positive regard. Further, in order to feel connected or re-connected with humanity, the young men needed to feel they could trust 'humanity'. Through developing a sense of trust in the mental health worker, they were then re-connecting with another person; taking the first tentative steps towards re-connecting with the wider community of 'humanity'.

4.3. Core Category and Phase Two: On Becoming a Man ...

This core category is comprised of six initial categories:

- Gently challenging unhelpful and unrealistic perceptions of what it is to be a (successful) man in 21st century Northern Ireland;
- Mixing with people in similar circumstances (current and past);
- Being exposed to testimony of (previous) suicide attempters;
- Understanding that having thoughts about suicide is quite common, normal and not necessarily pathological;
- Helping young men understand that life can be, and often is, hard and has to do with enduring suffering;
- Receiving counselling for specific and unresolved issues e.g. previous bereavement, childhood abuse, addiction.

Figure 3: Core Category and Phase Two: 'On Becoming a Man.....'



This core category is concerned with the interventions, programs, activities and services that need to be provided to suicidal young men, once they have gained access. Data provided by the participants indicated a range of issues, problems and perceptions that were significantly contributing to their initial and ongoing increased risk for suicide. Accordingly, analysis of the data identified a range of interventions, programs, activities and services that could be offered as a means to combat these.

Participants made reference to possessing certain perceptions of what it was to be a 'successful' man in 21st century Northern Ireland. Moreover, these perceptions were by and large, unhelpful, unrealistic and unobtainable (some might say 'immature') and served to contribute to their low self-esteem, level of personal stress and ultimately, to their increased risk of suicide. Accordingly, one role of MHPs, especially those who worked closely and interpersonally with suicidal young men, was to gently challenge these constructs and perceptions and replace them with more realistic, helpful and much more attainable views of being a successful man. Specific constructs that appear to have contributed to increased risk of suicide, and thus require gentle challenge, include: the societal stigmatized view of young men who talk openly about their feelings, problems and seek help; the view that suicide was associated, rightly or wrongly, with madness and weakness; the view that successful men had high-powered (meaningful) jobs and lots of money, access to girls and importantly, successful men are certainly not gay, and further; the view that successful or 'real men' were tough, strong and that they do not need help, do not admit intra-personal difficulty and they certainly do not admit to psychological problems.

Ugh, low self esteem, I've always had low self esteem and I never thought I would amount to anything ... because my uncle he was like a millionaire ... and all his sons were going on to go to [university], and all, and my father always expected....these things in your head telling you that you are never going to amount to nothing and everyone else is better than you....look at so and so out working away, look at the car he's driving. (*Interview 2*)

A further construct that served to increase the risk of suicide for the young men in this study was the view that having thoughts about suicide was uncommon, and that having such thoughts designated them as 'mad' or 'different.' Accordingly, this core category is concerned with replacing these inaccurate and limiting/damaging perceptions with accurate, useful and helpful perceptions *vis-a-vis* suicide and having suicidal thoughts. Namely, that having suicidal thoughts and feelings is actually common in young men in Northern Ireland. Evidence for the prevalence of such thinking has recently been provided in McHugh's (2010) survey of young jobless people in Northern Ireland, in

which he discovered that more than a third of jobless young people in Northern Ireland have felt suicidal at some stage. Of the 52,000 youths unemployed or not in training or education, 35% said they had felt suicidal, while 32% (over 18,000 young people) said they were depressed all the time and 27% felt they had nothing to look forward to in life. Moreover, over 18,000 had considered taking their own lives because of the emotional impact of losing work.

Another limiting construct was that of the private nature of suicide. The young men in this study maintained that suicide was very much a private matter. This privacy and unwillingness to share or discuss their suicidal thoughts and experiences further contributed to the perception that suicide in young men is uncommon. Suicide in young men then, for the most part remained an unspoken phenomenon until they came into contact with other young men who have had similar experiences.

I don't like to talk to them too much about the suicidal thoughts because I don't want to upset them, but I have talked to my two closest friends about the thoughts, and, you know, em [sighs]...I don't think they really knew what to say or how to ... So I don't like to talk to them about it because I don't want to, you know, scare them too much. (*Interview 19*)

I have a load of mates and that there, so I would. Not really something you would say. Just waiting for the time to pass, sort of, do you know what I mean? ... they would talk about it if I bring it up. It's just something that I don't find very comfortable.... It's ... what are you supposed to say, do you know what I mean? ... You don't talk about it with the wider circle, just your main friends. But it's just whether or not you want to bring it up. (*Interview 54*)

The next element of this core category is connected closely to those already highlighted and is concerned with suicidal young men gaining an understanding of the fact that life can be, and often is, hard, and has to do with enduring suffering (in a variety of forms). This is perhaps indicative of another inaccurate and limiting/damaging perception, namely, constructs about an 'easy' or 'problem free' view of life. This construct refers to being surprised by encountering major difficulties and challenges, emotional problems, and having disappointment after disappointment. Statements offered by participants indicated that no-one had taken the time to work with these young men and explain that

life can be, and most likely will be, hard. It seemed that the existential truth (if such a thing exists) that under the best of conditions, life is short, periodically painful, fickle, often lonely and anxiety provoking, had never been brought up previously. No-one, it seems, had explored with these young men how all human beings share the following experiences: mortality (finite), sickness, pain, fickle and unpredictable life-course, psychological burdens and stress, mental health difficulties (e.g. variations in mood, experiencing anxiety) (Maris *et al.*, 2000).

These views echo those of the holocaust survivor and noted psychotherapist, Victor Frankl (1959), who has argued that life, almost inevitably, is about suffering. Similarly, the significant and noted contributor to contemporary suicidology, Professor John Maltzberger, draws attention to the imperfect nature of life and living, and the pivotal developmental task of accepting the limitations of life.

“Successful adulthood demands that one must passively endure disappointment over and over again....Maturity demands that one must accept passive suffering without flying into rages against life or against one’s body” (Maltzberger, 2004, p86).

With respect to the interventions, programmes, activities and services that need to be provided to suicidal young men, the study data suggest the following. One such service is access to a ‘peer group’ where they can find comfort, support and hope in being able to mix with people who have either previously experienced or are currently experiencing similar circumstances and situations and survived. Being amongst others who were ‘the same’ created an opportunity for the young men to vocalize how they had been feeling in a forum in which they were not afraid of being labeled as crazy, mad or weird. Being amongst others who had been through the same or similar challenges thus served to normalise suicide, normalise their difficulties, and, ultimately, normalise them as human beings. The participants referred to the significant therapeutic effects of finding out that they ‘were not the only one like this’.

I just think we really need to start changing the way it’s portrayed. I just don’t think it works – especially being that age, and for young men, as I said, don’t have the mental acuity to understand why they are

feeling that way, or just can't open up. They're going to be all macho and bravado. Just get them around and sit down and talk it through, is not necessarily the right way to do it, in a almost peer to peer, face to face, reviewed it - to dig back down. (*Interview 59*)

I think there should be an anonymous drop-in centre somewhere. At least somewhere where someone, even if the people that are counselling aren't within the immediate area because young men do need to speak to someone and whenever they speak to their family or their friends there is a stigma if you are talking about suicide, you're nuts, you're schizophrenic, you're paranoid and all this here. And it's ok saying, 'Here is the Samaritan's, here's Lifeline', but you automatically think that's the last resort and there should be somewhere were personal interaction with someone who is willing, who is thinking about it, is probably the best way to get through to them. (*Interview 63*)

Mixing with 'peers' (in some cases this was operationalised as a form of post-suicide support group) helped the suicidal young men realise that other young men have had intrusive suicidal thoughts, have experienced extremely hard life-circumstances, and have felt ashamed and alone because of these feelings. The young men in this study, when mixing with others who were 'like them', also found that some of the individuals they mixed with became living, physical examples of the 'reality' that one could indeed live a long and fulfilling life even after making a serious attempt(s) on one's life. Such individuals served as palpable examples for the participants that a hope filled future was entirely possible and within their reach.

Further, mixing with other (formerly suicidal) young men inevitably brought participants into contact with testimonies from people who had previously made and subsequently recovered from a serious attempt(s) on their life. Such testimonies highlighted to the young men that recovery was and is possible and provided some form of conceptual understanding of what one was likely to go through in order to 'recover'. Additionally, hearing these testimonies served to further challenge the mis-perceptions of what is was to be a 'real man' in Northern Ireland. These 'real men' were, after all, offering testimonies that directly challenged mis-perceptions such as 'big strong men solve their problems on their own, don't show their feelings and never even think about taking their own lives'.

In addition, a further process captured in this category identifies that hearing these testimonies actually served as a protective factor against future suicide attempts. Hearing (in 'gruesome detail') the facts about making an attempt on one's life and on coming to terms with the harsh reality of nearly dying (as well as, in other contexts, learning of the intense grief and suffering of those who had lost someone to suicide) directly ushered the suicidal young men into thinking 'that could be me/my family?' It was harder for the young men to adopt a position of bravado and a cavalier attitude towards an event that was unpleasant, scary, and difficult to hear about.

....and that there sorta saved me because I seen the devastation... 'cause I've seen the devastation it causes ... and I can't do it ... on my parents ... it saved me like ... because I, I thought after the last time if I carried on the way I was I'd end up like him as well, cause I....I don't have as much control over yourself you know ... It sorta freaked me that I am going to end up like himcause that there and it was like...you're sorta seeing the similarities between....you and him and you're going, hang on, am I going to end up like this ... am I? (*Interview 14*)

Once the young men were exposed to their 'peer group', inaccurate perceptions were quickly dispelled as it became abundantly clear that suicidal thoughts, feelings and experiences were far more common than they thought. Furthermore, this exposure to their 'peer group' brought them into contact with other 'real men' so that these inaccurate, machismo driven views were challenged. They also found that even amongst 'real men', experiences and thoughts of suicide are relatively common. It again appears that a key aspect of any proposed program/treatment to help these young men should include helping them understand that these issues are common, normal, healthy and maybe even necessary. They are perhaps suggestive of part of the process(es) of becoming a grown adult man, that there is nothing pathologically wrong with experiencing shame, failure, etc. and that an essential part of becoming a man is learning to deal with such disappointment (see Maltzberger, 2004) and re-arranging one's dreams and ambitions.

With respect to the interventions, programmes, activities and services that need to be provided, the issue of suicidal young men often needing and subsequently gaining

access to counselling (therapy) for specific and hitherto unresolved issues in their past is paramount. Participants referred to a wide variety of problems and issues for which they wanted/needed counseling/therapy, each of which, to a greater or lesser extent, was contributing to their risk for suicide. Data provided by the participants and the subsequent conceptualisation of this material repeatedly indicated how the young men in this study had problems such as:

- a) physically, emotionally and sexually abusive childhoods and backgrounds;
- b) poor or low self-image, self-esteem, and negative perceptions of self;
- c) relationship difficulties and breakdowns;
- d) loss and bereavement;
- e) addictions/dependency on alcohol, substance (street drugs), gambling, prescription pills;
- f) general and specific anxieties, and;
- g) unhelpful/dysfunctional family dynamics.

Accordingly, a wide variety of forms or types of counselling services were required (for example, counselling for abusive background involving Dialectical Behavioural Therapy (DBT) or Cognitive Behavioural Therapy (CBT), relationship/marriage counseling, counselling for addictions and dependency, loss and bereavement counseling, and family therapy). Evidently, where the suicidal young man had received such specific forms of help, he found it useful.

Furthermore, the data in this study indicated that these unresolved issues not only had a pervasive and deleterious effect on the lives of the young men but, as indicated above, contributed to their increased risk of suicide. To begin to address some of these unresolved issues from their past would be to, *ipso facto*, simultaneously address their increased suicidality. It is noteworthy that participants stayed clear from suggesting direct causal relationships between the events in their past and their current suicide risk. However, it was apparent that these events and their respective intra-personal legacies made up an important part, but only a part, of the young man's overall suicidality.

4.4 Core Category and Phase Three: Equipping Young Men for the Challenges of 21st Century Living

This core category is comprised of four initial categories:

- Helping the person (re)discover and find (new) meaning in life (exploration of existential issues);
- Obtaining and refining pragmatic life/social/educational skills and practical support;
- Re-kindling supportive family connections;
- Embracing and engaging in the longer-term work of recovering from suicide.

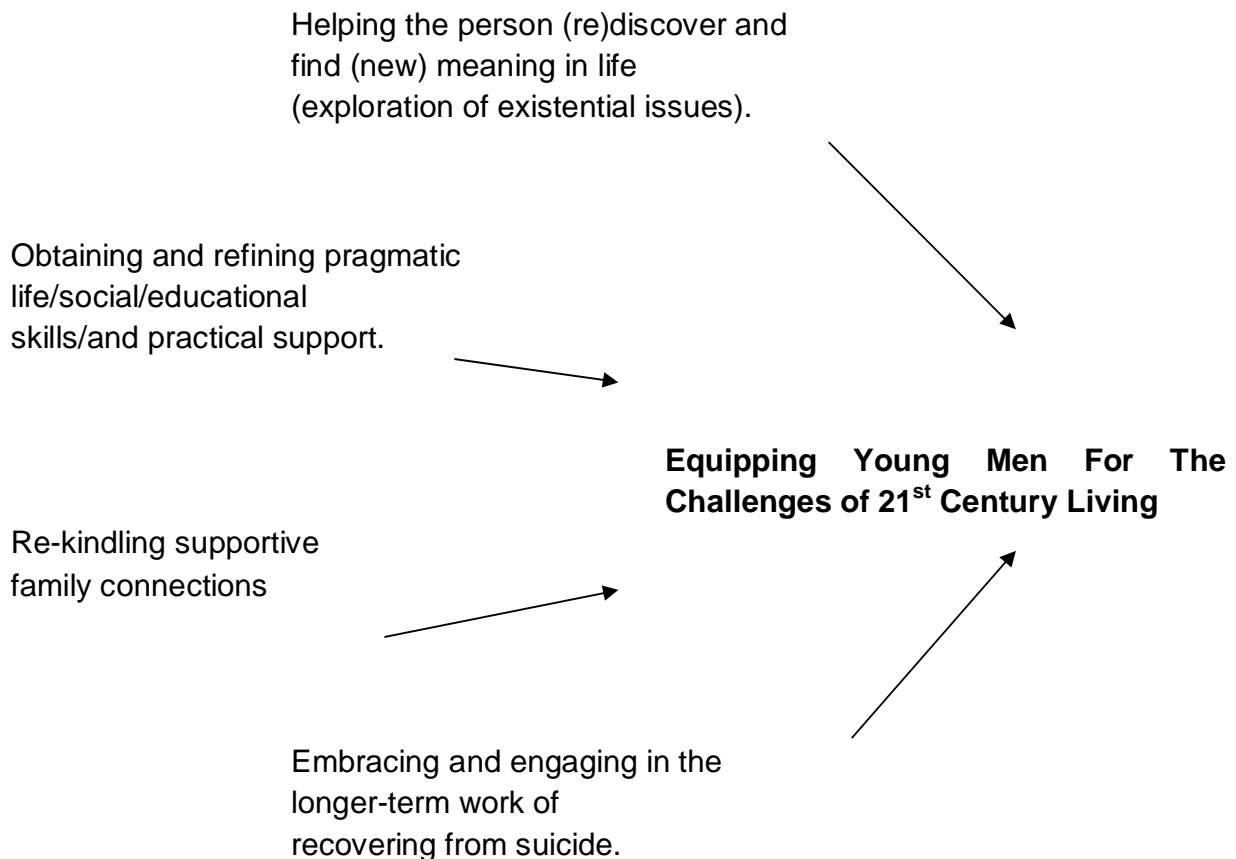
This core category is concerned with the processes and activities with which the young men engaged in order to embrace their path to recovery from suicidality. It indicates and captures how this 'journey of recovery' from their existential crisis of suicide was seldom completed quickly or easily. The Core Category shows how recovery from suicide appeared to involve (re)discovering meaning in the young men's lives. Individual ways and means that this (new) meaning was found or created varied from participant to participant, though there were distinct commonalities across the group of young men.

This core category is also concerned with providing the suicidal young men with a range of opportunities to engage in pragmatic life skills, social skills, educational programmes and meaningful activities, all of which to a greater or lesser extent are concerned with equipping them with the skill (and attitude) set that is required for surviving (and maybe even thriving) in 21st century Northern Ireland.

This core category is also concerned with the suicidal young men being aware (or becoming more aware) of the powerful protective factor that having close, loving, concerned family members can provide. In addition to increased awareness, after the young men had made an attempt on their lives, there was particular therapeutic value and thus an enhancement of the protective effects of close relationships with family members.

Finally, this core category is also concerned with the suicidal young men becoming aware of, acknowledging and embracing the reality that 'recovery' (for want of a better term) from their suicidality was going to be a long process. And that within this longer time frame, there would be hard work that they would need to engage in. There is also a sense that while they were willing to engage in this long-term work, they would require ongoing support and involvement with the mental health services and others who have endured a similar situation.

Figure 4: Core Category and Phase Three: Equipping Young Men for the Challenges of 21st Century Living



4.4.1 Initial Category One: Helping the person (re)discover and find (new) meaning in life (exploration of existential issues)

This category is concerned with the suicidal young men growing in awareness that their lives appeared to be lacking in personal meaning. It is concerned with their increasing sense of dissatisfaction with a 'meaningless life' and how MHPs could subsequently help the young men explore and discover and/or re-discover personally meaningful phenomenon and experiences in their lives. As a result of finding new meaning and purpose, the elevated risk of further suicidal attempts appears to diminish.

Data provided by the participants and subsequent conceptualisation of this material repeatedly indicated how the young men in this study made reference to their endeavours to find new meaning within their new 'lease of life' (e.g. post suicide attempt). This was bound up with new beginnings, with creating a new narrative of their situation, deliberately re-organizing and restructuring their lives, and with a sense of starting 'anew'. There was a distinct process of leaving 'what has gone' in the past and, to some extent, reframing how some of this past was viewed and seeking a new perspective on their present and future. However, finding or searching for new meaning appeared, in some cases, to be prefaced with a growing sense of discontent and dissatisfaction with their lives. The young men referred to how they were becoming aware of significant gaps in their lives; how they wanted answers and/or to achieve specific goals/aims; how they were bored and not getting a 'buzz' out of life. Some spoke of how they became aware that they were at a loss as to what meaning their lives had.

And...it just seemed like a lifetime of failure, like no sort of...you know, jumping from job to job. ... I also, em, have a son from another relationship that I've never seen as well. It just seems...looking back on my adult life, it just stemmed from like one failure to another. ... And then the gambling on top of that, and it just...it just sort of seemed that everything...that my life was a complete failure. (*Interview 62*)

Every path that I could see myself going down, I didn't want to do that, and it just seemed that every line of thought I took...it sort of ended, that train of thought ended in me killing myself basically, because I had no...I could see no other way of coping with life. (*Interview 19*)

Participants repeatedly made reference to their need and search for new meaning which could be found, for example, in the following ways:

- a) forming a new, or renewing a former, significant relationship;
- b) focusing and developing the bonds with family members (and/or creating new bonds, for example, becoming a parent themselves);
- c) considering career options, searching for and subsequently finding a meaningful job;
- d) engaging in personal development (e.g. finding their place in the world);
- e) exploring spirituality-related issues;

- f) going back to educational programs/courses, taking new training, acquiring new skills and importantly, and;
- g) helping others who were experiencing similar problems with suicide and offering themselves as a resource to these people.

I have made a conscious and deliberate decision to get involved in the community activity. ... I'll be working in one of these groups [few words inaudible] a wee bit myself. (*Interview 69*)

... you know what my dream was, you see, I done something when I was in the Army, I could have saved the world, you know, I could have saved the world, you know that kinda way. But I realise now some things are out of reach and like that there. (*Interview 26*)

It is noteworthy, and perhaps not altogether surprising, that many of these activities concerned with finding and/or creating new meaning in their lives are almost direct opposites of the phenomena, events and experiences that were reported as contributing to their increased suicidality in the first instance. For example, while dysfunctional family dynamics (and the abuse that can accompany this) was reported to be a significant contributor to their suicidal ideation, having loving, supportive, and significant relationships and bonds with family members was described as bringing new meaning to their lives. While having no job or a meaningless job was reported to be a significant contributor to their suicidal ideation, having interesting, fulfilling or at the very least, a job with a future, was also described as bringing new meaning to the lives of the young men.

We have been going out for about a year and a half – I have known her a couple of years, but she's the first person that I've opened up to about it. ... Just confident in the strength of our relationship. As I said, that's why I think I'm slightly better articulating how I feel, than others, but she actually was the one who noticed in the paper and said "I think you could actually benefit others by going to this [the research interview]." (*Interview 59*)

Now things have got very, very good. I have lovely children, and I have three boys, and I really enjoy my life now and I realise what I do have. (*Interview 43*)

Furthermore and importantly, it is also particularly noteworthy that participants found much meaning in 'doing for other people', particularly other people who were

experiencing similar challenges. According to the data supplied in this study, there appears to be particular utility and value (as a suicide deterrent) to be involved in helping other people overcome their own challenges with suicidal thinking and actions.

So I took a positive approach to everything. I chose to do that, and that was the thing for me, like empowering. I chose to stop allowing it to happen to me. ... And for me now, I have – I have worked with our own GPs to promote mental health awareness, and to have different numbers for different groups. (*Interview 57*)

4.4.2 Initial Category Two: Obtaining and refining pragmatic life/social/educational skills and practical support

This category is concerned with the suicidal young men being provided with a range of opportunities to engage in pragmatic, life skills, social skills, educational programmes and meaningful activities, all of which to a greater or lesser extent are concerned with equipping them with the skill (and attitude) set that is required for surviving (and maybe even thriving) in 21st century Northern Ireland. There is also a less 'grand' purpose, that is still important and useful, and this is concerned with keeping the young suicidal men busy, combating their boredom and cutting down on the time that they can spend in unproductive rumination.

Data provided by the participants and subsequent conceptualisation of this material repeatedly indicated how prior to making an attempt on their lives (or ruminating seriously about so doing), the young men appeared to lack certain coping skills that might have helped them deal (to some extent) with aspects of their unfortunate life circumstances. For example, the data indicated that some of the young men had significant difficulty in dealing with disappointment, less than satisfactory outcomes, dashed hopes and 'failure'. Others appeared to lack the ability to self-motivate and/or problem-solve; others referred to their problems in dealing with (interpersonally produced) stress. Without these coping skills, the well-documented and pronounced problems of living as a young man in 21st century Northern Ireland (e.g. facing high unemployment rates, availability of 'street-recreational drugs', post-Troubles politics {e.g. legacy of sectarianism}, a faltering economy if not an actual economic depression,

the 'singular' relationship between 'Westminster' and Stormont – to name but a few) clearly contributed to, and exacerbated, the young men's risk of suicide. Accordingly, providing the young men with a wide-range of intra and interpersonal skills that would help them deal with these very real and everyday issues, serves potentially as a powerful suicide deterrent.

... but my own thoughts are – you need to have something to aim for. They need to have something they want to do, so if it's trying to push people towards joining a club, so if you're out playing football, or a sport, your energising, you're using energy, you're making friends. You are socialising. You are taking yourself out of it, and you're starting to become more aware of what's around you. (*Interview 59*)

Someone just to say, you know, volunteers or something to go and take people out and, you know, do something fun with them, to take their mind off it, but who they can also talk to about things, you know, if they need to talk. (*Interview 19*)

There is some conceptual overlap between this category and Initial Category One: Helping the person (re)discover and find (new) meaning in life (exploration of existential issues, but this category has additional processes, most especially those concerned with equipping the young men with the wide range of skills required to navigate one's way successfully through the contemporary challenges of life in Northern Ireland and keeping the young men occupied with meaningful activities to avoid exposure to too much isolation and rumination.

Yeah, and especially like – I know like teenage years are rough on any generation but with sort of the circumstances and things changing from time periods it's a lot sorta harder to see the full picture value – in my history's point of view, so it's just sorta getting like teenagers and young people in together and giving them the skills to help themselves and others. (*Interview 32*)

So I went up to them ones and I had a sort of brief chat with this fella and he says great.....they had like a men's group who met every Wednesday and they done wee courses and shit like ahm ... anger management and stress relief, all that, all these different course, so I ended up going to them for a couple of years.....still a member, like I go now and again.... And I did some educational programmes as well. I done a load of courses. (*Interview 10*)

4.4.3 Initial Category Three: Re-kindling supportive family connections

This category is concerned with the suicidal young men being aware of the powerful protective factor that having close, loving, concerned family members can have on them.

Easy. Family. I have a brilliant wife – the best wife in the world and three beautiful children. I have a daughter at seven, and two boys at four and two. (*Interview 67*)

There is also a sense of guilt involved in this category; and that guilt also serves as a protective factor. The young men in this study expressed how they were unwilling to hurt their family (through the action of harming themselves); they consciously thought about the effect(s) that taking their own life would/could have on their close family members.

Suicide has got to be the most selfish thing a person can ever do. You know, I know it's a terrible thing that they must be feeling so bad that that's what they actually do, but it's a dreadfully selfish thing, and I just...I [only]...I could deal with...handle the thought of how much pain I was going to be causing, well, my family and my friends.... (*Interview 19*)

I'd honestly say the only thing is...em, the guilt of putting my family through what it would do, because I know, whenever that starts in my head and I start thinking about and considering it, you know. ... I thought it would take the hurt away from my family, you know, that, well, this is why he done it, but it never will. So whenever them thoughts come, I just sit and argue with myself, and tell, you know, whatever this thing is that's trying to tell me to do it, that I can't, and talk my way through it, and just have this wee argument (*Interview 39*)

To a lesser extent, this category is also concerned with the participants being unwilling, at times, to speak about their suicidal thoughts/feelings as a way of protecting family members. In these circumstances, the family connection, paradoxically, seemed not to act as a protective factor as it inhibited the young men from communicating their distress. Data provided by the participants and the subsequent conceptualisation of this material repeatedly indicated there was a further process in this category. After sharing their suicidal thoughts/feelings with selected family members, participants needed to gain the acceptance of their significant others and family; to not be rejected as a result

of their suicidal act (or thoughts/feelings). Such acceptance effected participants' outlook for the future, made them feel more hopeful. Participants who were seeking to re-invest in and move forward with a 'new lease of life' described needing the support of these significant people in their lives.

My dad was really just supportive, he understood why I did it but he also thought that I shouldn't. ... But my father sat me down and he talked through things with me, he helped me out with my money worries, my brother was there for support whenever he needed it for someone to talk to.

(Interview 63)

No, because as soon as I explained it to my parents and we, you know I shared it, it lifted. It was grand. ... They weren't, one maybe where I was very, very suicidal, but I didn't do anything about it, because my parents knew, they knew I was bad. I didn't want to put them through the again. *(Interview 29)*

4.4.4 Initial Category Four: Embracing and engaging in the longer-term work of recovering from suicide

This category is concerned with the suicidal young men becoming aware of, acknowledging and embracing the reality that 'recovery' (for want of a better term) from their suicidality was going to be a long process. And that within this longer time frame, there would be hard work that they would need to engage in. There is also a sense that while they were willing to engage in this long-term work, they would require ongoing support and involvement with the mental health services and others who have endured a similar situation.

It took a while for us to make headway I guess but I guess I stuck with it and he stuck with it, so we did make progress eventually you know, at the start it didn't seem as if we were getting anywhere. *(Interview 28)*

Some days it can be a bit harder than others, especially, you know, because my father still knows the buttons to press, and because sometimes I have to struggle to work in the morning and other days it could take me a couple of hours before he does that – before I can do that to stop him. But that would be where I am now. ... I think I'm actually quite a strong person, because I have survived what has happened, but that has been the process I have gone through, and it has taken years for me to realise I have the choice. *(Interview 57)*

To a lesser extent, this category is also concerned with the participants beginning to 'pick up the threads' of their life and, in essence, learning to live again. According to some, this included the important process of 'making sense' of their suicidality; this shifted the sense of the existential crisis from 'what do I have to live for' to 'how do I go on living in the context of surviving a suicide attempt?' Participants alluded to how, rather than dismissing their suicidality, it had to be made sense of. Interestingly, none of the young men in this study referred to this process of 'sense making' in the past tense or as something they had completed. It was clear that, for these participants, this was going to be a lengthy and complex process. Additionally, it was evident that a number of inter and intra-personal processes were involved, not least the continued support from and involvement of (in this instance) the MHPs and fellow 'travelers' on the 'recovery' path.

Don't get me wrong. There's days you are up and down, and it's probably just like getting that sort of function. You are still up and down, but like – then sort of – I'm actually pretty relaxed today. Tomorrow I could be uptight and just some would just say and I would lose the rag with them. You are up and down a wee bit and I find that about myself at the minute. I don't find it easy. (*Interview 69*)

Every now and again the thought would still sorta creep in, but I've basically just...my plan has been trying to teach myself as not to have it as an option.... So that's more or less worked, but like as I say it just now and again sorta creeps in but I just keep sorta tell myself that that can't be a choice, that's not an option. (*Interview 32*)

Crucially, the regularity with which the young men who participated in the study sought, often spontaneously, to try to make sense of their suicidality in the context of moving forward with their lives, demonstrates how such sense-making is, fundamentally, a very 'human' thing to do; the very fact that it mattered to the participants was an indication that their connections with humanity were intact and strengthening.

Chapter 5: Discussion

5.1 Introduction

In this chapter the findings of the study are summarised and subsequently interpreted in the context of evidence drawn from the extant literature. The chapter continues with an examination of the strengths and limitations of the study as well as wider issues relating to the conduct of the research. Finally, using this collective evidence, the chapter concludes by setting out a series of policy and practice recommendations for how care of young suicidal men might appropriately be developed.

5.2 Summary of study findings

The findings were derived from interviews conducted with thirty-six young men aged between 18-34 years old. The interviews provided them with the opportunity to discuss their experiences of being suicidal. This discussion included the care they received from both statutory and non-statutory services. Analysis of the interview data identified three core categories, each related to specific phases of a young man's recovery from suicidal thinking and behavior.

The first category, *Widening Access and Bolstering Pro-active Outreach*, identified four attributes of appropriate service configuration and care provision. Taken together, *'Encountering pro-active suicide prevention programs'* and *'Having access to community-based, effective (and informal) suicide support centres'* highlighted the need for services which reach out to young men pro-actively. This included by way of community based venues which provide clinical care but in contexts which are manifestly informal and otherwise concur with young men's preferred means of social interaction. The requirement for *'Encountering mental health practitioners (MHPs) who possess and convey therapeutic and supportive (non-judgemental) attitudes'*, identified core MHP qualities and skills which lie at the heart of meaningful therapeutic engagement as perceived by young men. These included possessing and, crucially, exhibiting 'human' qualities such as empathy, compassion, warmth, interest and genuine care and concern. All of these qualities needed to be underpinned by an

explicitly non-judgemental approach that encouraged a young man to 'open up' and to gain confidence in himself and the therapeutic value of the relationship between himself and the MHP. Finally, '*Re-connecting the person with humanity*' highlighted the vital importance of MHPs in combating the pervasive sense of disconnection young suicidal men experienced. By demonstrating their care and concern, a MHP played a central role in reinforcing a young man's appreciation of his connection to others, thereby countering his sense of isolation, lack of personal worth and suicidal thinking.

The second category '*On becoming a man...*' was concerned primarily with the circumstances and processes required to facilitate a young man's continuing recovery. The need for a diverse 'mix' of care which moved beyond the alleviation of immediate suicidal risk and continued over the longer term was identified. In terms of facilitating young men's onward trajectory through life, this category highlighted the value of equipping them with an appreciation of both the (harsh) 'realities' as well as the (exciting) possibilities of and for human life. Further, the category underlined the value of exposing young men to the testimonies of others with experience and 'survivorship' of suicide, as a practical means of instilling this appreciation. Again, in the context of equipping young men for onward recovery from suicide, this category drew attention to the need for counselling therapy to help resolve a wide range of contributory issues such as previous bereavement, dysfunctional family relationships and addiction.

The third and final category, '*Equipping young men for the challenges of 21st century living*', again highlighted the need for support delivered over the longer term, this time in the context of (re)building a meaningful and rewarding life. In essence, relevant support moved away from that focused on recovery from (the risk of) suicide to helping create the circumstances in which suicide would no longer be considered a relevant option by young men. The need to enhance their appreciation of the potential for (new) meaning in life and to provide the necessary support, skills and social and cultural environment to actively pursue this (new) life, was highlighted. At an individual level, (re)forming significant interpersonal relationships and acquiring relevant life skills were shown to actively contribute to young men's ability to both conceive and subsequently pursue this

(new) meaning. At the level of society, the removal of barriers such as stigma and discrimination was shown to be central to their ability to benefit from the full range of social and economic opportunities. Lying behind young men's endeavours to achieve this 'new' life, was (their awareness of) the necessity of engaging in an *ongoing* process of recovery. In significant measure, this process enabled them to make sense of their suicidality in the context of learning to and being able to live (again). Here, the continuing help and support of others, including MHPs, was identified as important.

5.3 Discussion of study findings

For the purposes of clarity and utility, the discussion of study findings is structured around the two research questions which underpinned the design and conduct of the study.

(1) How can mental health care services be most appropriately configured to encourage their use by suicidal men aged 16-34?

In terms of the appropriate configuration of services, findings highlighted the need for suicide prevention programmes which reach out to young men *pro-actively*, in addition to providing responsive or reactive mental health services. In line with the literature (see, for example: Barney *et al.*, 2006; Biddle *et al.*, 2004; Oliver *et al.*, 2005; Renaud *et al.*, 2006), the study identified an under utilisation of *mental health* services. The research goes further than many of these previous epidemiologically informed studies in that it addresses the underlying reasons for this lack of engagement from the perspective of young suicidal men. In so doing it highlights a pervasive understanding of current services as both stigmatised and stigmatising, as being inadequately available to young men in need and, where access is achieved, as lacking (at least, consistently) the necessary qualities to provide meaningful and effective care. These findings can be used to provide key messages regarding the appropriate arrangement and content of the necessary pro-active services.

Services that are embedded in the local community are of particular merit for a number of reasons. They are more likely to be *informal* in nature based, for example, on their

association with social interaction *per se* (as distinct from interaction focused on clinical, mental health oriented care). In addition, they are more *easily* and *discretely* accessed, increasing the likelihood of contact at the time of need and, crucially, in ways which are seen to protect a young man's anonymity and confidentiality. This thinking is supported by findings from a range of internationally conducted research studies that have sought to understand (young) men's reluctance to engage with formal health care (Centre for Suicide Prevention/Canadian Mental Health Association, 2007; Burke & McKeon, 2007). One study, conducted in Ireland by Russell *et al.* (2004), theorised that the most likely reason for this pattern of behavior was that of perceived stigma. Based on this and related findings, the authors recommended that activities connected with young people's emotional and mental well being are most appropriately delivered in places where they are *ordinarily* present. Useful as the findings of such studies are, they are limited by the fact that they are based on research conducted amongst the *general* population of (young) men. Our research, undertaken specifically with young men who have experienced suicidal behavior and/or thinking, is of particular merit in being able to provide a unique insight into services that young men are likely to access and find effective, including at times when they are actively suicidal. The findings endorse the appropriateness of embedding mental health related services in locations and venues with which young men are familiar. These 'contexts' of engagement will present as relatively 'ordinary', informal and otherwise promote social interaction.

The importance of maximizing accessibility has been highlighted by research focusing on the population of suicidal individuals *per se*. Tondo *et al.*, (2006) used data from across the U.S. A. to demonstrate a strong correlation between suicides and access to healthcare, and argued that clinical intervention was the crucial element in the prevention of suicide. Taken overall, the crucial requirement of accessibility, as promoted through services which provide anonymity and informality, is well supported by the findings of this study and those delivered by other researchers.

Extrapolating from the findings, there are a number of ways in which this accessibility could be enhanced within *community* based mental health services. There is already a number of such community based, suicide-related initiatives operating across Northern

Ireland. These could be usefully harnessed to increase initial access by young men including, for example, through outreach work in schools, youth clubs, sports clubs etc. Moreover, community-based services can act as a firm foundation for engaging young men in the full range of clinical care they may require by way of onward referral to statutory mental health services. Current examples include the joint working between statutory and non-statutory mental health services throughout the Southern Trust. This is exemplified by the Research and Best Practice Committee which brings together a wide range of service providers to help develop and implement mental health and related services. There are also pockets of well developed statutory and non-statutory working within the Belfast Trust (for example, that associated with the work of the Self-Harm/Personality Disorder Team). Such examples could profitably be used to inform strategic thinking around how cross-sector services could be developed and implemented to promote access to care for young suicidal men. Fundamentally, the need is for services which 'go out' to young men and thereby promote their engagement.

One of the ways in which community based pro-active outreach services are conceptualised in the literature involves 'gatekeepers' (Gould & Kramer, 2001). These are people who are in regular contact with young men (for example, sports coaches, voluntary workers, youth officers, teachers, members of the clergy). Their involvement in community level suicide work makes sense in terms of the views expressed by young men in this study who stressed the value of the support they received from those with whom they came in contact in contexts other than clinical care. Russell *et al.* (2004) identified a similar preference among young men to approach those they regarded as non mental health professionals at times of emotional distress. They highlighted how these individuals already possess personal attributes and skills to make a gatekeeper (suicide prevention) training strategy viable. This finding reflects those of a recent study of the emotional needs of 16 year olds in Northern Ireland, commissioned by the Patients and Clients Council (Schubotz & McMullan, 2010).

Participants in the present study talked about the perceived benefits of sports (either real or potential) to their and other suicidal men's mental well being. Such thinking and related behavior has been identified among young men in Ireland (Begley *et al.*, 2005) and elsewhere (Centre for Suicide Prevention/Canadian Mental Health Association, 2007; Harden *et al.*, 2002). Consequently, the findings of this as well as other research highlight the potential of sporting and other creative activity as a (relatively low cost) coping strategy for young suicidal men. Moreover, the relevance of sports coaches and other gatekeepers involved in sports for the promotion of mental well being among young men (including facilitating their access to mental health services) is supported. Here, the present study goes further than previous research because it underscores the validity of sporting and related activity based on talking to young men who have been actively suicidal. Further, it helps identify the underlying basis of (perceived) effectiveness, including the fact that physical exercise provides important opportunities for social interaction.

This study is one of the first to confirm the value of suicide related outreach work using media that have become a regular means of communication among young people. Such media include, but are not necessarily restricted to, social networking systems, the Internet, text messaging and email. In this context, van Spijker *et al.* (2010) highlighted recently how, in line with young people's preferred means of communication, the Internet provides an opportunity to reach suicidal individuals who would not be contacted otherwise. Participants in the present study described a range of means of communication with peers as well as information and other support seeking in relation to their suicidality. Their accounts are important in suggesting there is scope for extending and enhancing young men's engagement in services through diversification of the means of communication to encourage initial access as well as continuing use of services. That is, relevant therapeutic engagement could usefully include that based on these more novel forms of media. Not only does such means of contact/communication address concerns about stigma and confidentiality (see also Begley *et al.*, (2005)), but it reflects what is becoming increasingly common practice in terms of how (young) people interact. Although targeted at a different population, recent advice issued by the NI

DHSSPS endorses the value of Internet based therapeutic engagement, as it recommends GPs refer patients to the Internet CBT package called 'Beating the Blues' (NHS Access, 2010).

Participants gave powerful descriptions of the value of support they had received from a range of self-help groups or individuals who had experienced the same kind and/or degree of emotional distress. Here, the findings of this research are particularly innovative in suggesting the value of the principle of 'equivalence' to inform the development of community based services. These services would enable young men to mix with and, in the process, learn from others with experience of suicidal behavior as well as wider mental/emotional well-being issues. Such inter-action, and the help and support it engenders, again, in a manifestly informal manner, would appear to have the potential to provide extremely effective care. The accounts offered by participants confirm that once exposed 'close-up' to the reality and aftermath of suicide (particularly the devastation caused to the lives of friends and family), it becomes understood as something to be avoided, irrespective of personal pressures and incentives. The testimonies of participants point to exposure to the 'realities' of suicide as a protective factor, when this exposure takes the form of direct contact with the experiences of others (and their friends and families) who have themselves 'survived' suicidal behavior.

Learning about the experiences of other young people who have survived previous suicidal behavior can act as a powerful incentive for young men who may be either currently suicidal or in the relatively early stages of the process of recovery themselves. That is, the accounts of survivors may be particularly useful in helping these young men to appreciate, and see ways of personally coping with, the realities of day-to-day living over the longer term. This includes an understanding that having thoughts about suicide is quite common, normal and not necessarily pathological and that life can be, and often is, hard and has to do with enduring suffering. The association between peer pressure and suicide in young men may be mediated by a tendency in vulnerable individuals to make negative comparisons between themselves and other members of their peer groups (Russell *et al.*, 2004). Consequently, measures taken to promote engagement

between suicidal young men and their peers (and their associates) who have had the same or similar experiences can help alleviate this general tendency for negative comparison. In keeping with this line of thinking, Harden *et al.* (2002) highlighted the potential value of 'peer counseling' from their U.K. scoping exercise on the effectiveness of interventions for suicidal young men. Such counselling does not necessarily have to involve peers with direct experience of suicide. Nonetheless, the principle of learning from and being supported by others (perceived to be) relevant to the circumstances of their own lives, is endorsed.

The findings point to the benefits of involving family and friends in the process of helping young men to recover from suicide. Participants' reluctance to seek professional help was compounded by a failure to disclose their distress to anyone, including family and friends, at least until they had reached 'crisis point'. Other research that has investigated the help-seeking behavior of suicidal/emotionally distressed men reflects this finding (Cleary, 2005; Kapur *et al.*, 2005; Oliver *et al.*, 2005). The findings of the present study go further in that, as young men who had 'survived' suicidality, participants highlighted the importance of informal, social (family and friends) support networks in dealing with their suicidality, including recovery over the longer-term. Time and again participants laid emphasis on the importance of being involved within a family (or friendship) network to provide them with a sense of stability, purpose and a deep-seated *connection* to life. The most recent review of evidence concerning interventions relevant to suicidal youth, has shown how social support, especially from family, is an extremely important (protective) factor against suicide (Daniel & Goldston, 2009; see also, Mishara *et al.*, 2005). Moreover, the Harden *et al.* (2002) scoping exercise maintained that interventions for suicidal young men should include those which foster supportive relationships within families as well as other social networks. The findings of this study lend important empirical weight to their conclusions.

If family and friends (and, indeed, social 'others') are to be involved in providing support there is a need to consider how they may be equipped to so do. In this regard, family as well as peer support training delivered through a diverse range of social interaction, to

include, for example, community level (self-help) groups, schools and the workplace, is of relevance. To a certain extent, the programme of ASSIST training already underway in Northern Ireland is helping to provide relevant knowledge and skills. This could be usefully extended to be offered, for example, in different environments to a range of individuals and groups. Examples of other pertinent interventions include the Youth Participation Programme in Australia, which encourages young people to become mental health advocates. There is also the 'Step by Step' programme operating in Austria that trains teachers to recognise emotional problems in students (Burke & McKeon, 2007). A core principle informing the provision of all such training and support should acknowledge the need for diversity in terms of both the range of people involved as well as the locations / opportunities for its delivery. Once again, it is important to maximize access to such training and support.

(2) *What is the required response of mental health care services for suicidal men, aged 16-34?*

The qualitative nature of this research was particularly effective in gaining first-hand experiences of young men as to what are the important processes involved in effective care. Other research has tended to *abstract* what might be the constituent properties of such care from the accounts of (young) *non-suicidal* men. Above all else, it was seen as important that MHPs should possess and convey therapeutic and supportive (non-judgemental) attitudes. Crucially, such therapeutic attitudes included those which enable young men to *(re)connect with humanity*. There has been limited research into the specific processes required to enable such (re)connection. Nevertheless, findings parallel our own and suggest that at least some of the basic components of effective care-giving are shared for *all* suicidal individuals.

In line with previous research, this study demonstrates the importance of a strong relationship between client and health care provider in effecting positive treatment outcomes (for an early statement of the importance of building therapeutic relationships, see Rogers, 1951). Cusack *et al.* (2006) found that the bonding relationship and

perceptions of current treatment helpfulness were more important to future help-seeking intentions than a man's difficulty or discomfort with emotional expression. Our findings usefully build on such research to uncover what the particular dimensions or components of this relationship or 'bond' might be. Participants recounted, sometimes in very vivid terms, the deep sense of connection with, and concomitant therapeutic effectiveness of, particular MHPs. For the most part, their accounts dealt directly with perceived 'human' qualities which they associated with the MHPs' ability to meaningfully engage with, and *thus* to help, them. These included: commitment, demonstrated by acts of practical help and support; 'warmth' demonstrated by manifest active listening and responding; empathetic acknowledgement and appreciation of the young man's circumstances; genuinely caring for the young man's individual and holistic best interests, demonstrated by efforts to 'get to know' the young man as a person (and not a 'condition'); regard and respect for the young man as an autonomous human being, and; support to undertake a 'moving on' towards a (better) future. Informing all of these dimensions of care was the need for MHPs to remain non-judgemental concerning a young man's suicidality. The majority of the young men who participated in the study had experienced (sometimes extremely) negative and dysfunctional life circumstances and could remain emotionally vulnerable as a result. Consequently, there was a crucial need for a MHP to be explicitly and clearly non-judgemental about a young man's 'choice' to engage in suicidal behavior as well as to convey appreciation of the damaging personal context in which his suicidality emerged.

The relevance of these 'human' qualities in effective care giving has been demonstrated in the small body of similar work conducted internationally. For example, Sun *et al.* (2006:680), based on research conducted with Taiwanese psychiatric inpatients, identified the need for 'safe and compassionate care *via* the channel of the therapeutic relationship'. The properties of this care included the ability to: convey non-judgemental attitudes; provide strong support systems; 'be there', through, for example, attentive listening; demonstrate empathy; accept patients as individuals, be sincere; express kindness and respect for dignity, and; instill hope. In an earlier study, conducted with psychiatric inpatients in Norway, Talseth *et al.* (1999) highlighted patients' need for

confirmation during their interactions with nurses. Alongside attending to their physical requirements, this confirmation was achieved by the nurses' close interpersonal engagement with patients. This included: having time for patients, listening to them without prejudice, being open to patients (as displayed through body language and demeanour), accepting patients' feelings and communicating hope to patients.

More recently, Cutcliffe *et al.* (2006), based on a study of psychiatric inpatients in northern England, identified the key psychosocial process of 're-connecting the person with humanity' as synonymous with nursing care of the suicidal person. This process consisted of three distinct phases. The first, 'Reflecting an image of humanity', involved care which enabled the suicidal person to experience intense, warm, care-based human to human contact. This care was central to helping to challenge the person's suicidal thinking and to appreciate that they could connect with humanity. The second phase, 'Guiding the individual back to humanity', consisted of care which nurtured insight and understanding on the part of the suicidal person into their own thinking and behavior, including that which helped support and strengthen pre-suicidal beliefs. This 'guiding' could be achieved because of the uniqueness of the relationship between the nurse and suicidal person, one in which the latter felt able to talk freely and openly in a non-judgemental environment. The final stage, 'Learning to live', focused on the suicidal person's accommodation of their suicidality in the context of a re-engagement with life. Importantly, this re-engagement included a gradual building up of a network of connections to others, most importantly, relationships with family. However, the continuing need for nursing care to support the suicidal person in this stage of recovery was upheld.

The three research studies reported above were all conducted in a psychiatric in-patient context and involved a mixed (for example, gender and age) population. The present study was undertaken specifically with young men with experience of a range of care in different settings. Significantly, the collective findings endorse the validity of Shneidman's (1985) psychological theory of the aetiology of suicide, in which he suggests that all suicides tend to share common psychological features. Of these,

psychological pain or *psychache* is the single most important feature. Schneidman sees suicide as the human response to this extreme psychological pain, and believes that suicide prevention should focus on meeting the emotional needs of suicidal individuals. The findings presented in Chapter Four confirm the need for care to be delivered by MHPs that meets the basic emotional/interpersonal needs of young men. Participants needed to know that they mattered, that someone else was concerned about and interested in them. When a young man was able to perceive genuine caring on the part of the MHP, this had a specific countering effect on their suicidal ideation and perspectives. That is, the young men's sense of disconnect was directly countered by connecting with the MHP. Necessarily, fulfilling these needs will involve personal, face-to-face engagement between young men and designated MHPs with whom a trusting relationship can be developed over a necessary period of time and within which the properties of care outlined above may be forged.

The present study confirms that face-to-face, person-to-person, therapeutic closeness and engagement remain central to effective care. However, the research literature contains examples of other forms of support which are seen to meet *some* of the basic emotional needs of young men identified in Chapter Four. Clayton & Auster (2008) highlighted the value of what they term 'simple interventions' (2008: 17) as evidenced, for example, by the work of Motto & Bostrom (2001) and Carter *et al.* (2005). In the former study, a group of just over 3,000 patients hospitalised because of a depressive or suicidal state, were randomly allocated to a contact or a no contact group on discharge from hospital. The contact group received a monthly letter for 4 months, then every 2 months for 8 months, and after the first year, a letter every 3 months for the next 4 years and were followed for up to 15 years. The letters were always: written by the research staff member who had interviewed them in the hospital; individually typed; short; expressed concern that the person was getting along all right; worded differently; invited a response, and; included comments if the person had responded. In the 2,782 patients who could be followed for 5 years, the accumulated percentage of suicides was significantly lower for the first 2 years in those who got the letters compared with those who did not or those who at discharge claimed they were in follow-up treatment.

Although the rates remained lower for all 5 years, the difference was only significant in the first 2 years. The Carter *et al.* (2005) study involved patients admitted to hospital for a suicide attempt by self-poisoning who, on discharge, were randomly allocated to (i) treatment as usual (n= 394) and (ii) treatment as usual, plus eight postcards simply inquiring about their health over the following year (n=378). Although the percentage of repeaters was similar in the two groups, the number of suicide attempts greatly decreased in the group who received postcards compared with those who did not (101 compared to 192) because the repeats greatly decreased in female patients with three or more attempts.

Many of the young men who participated in our study talked variously about their sense of discontent, upset, frustration, even anger at what they perceived to be their relative lack of 'worth' or 'success' in life. They tended to make negative comparisons between themselves and others based on very rigid and narrow perceptions of what it was to be a 'successful' man in 21st century. In essential ways these perceptions can be seen to derive from traditional, hegemonic views of masculinity (Connell & Messerschmidt, 2005). Consequently, the present study lends important and original empirical evidence that any programme of care for young suicidal men should include a focus on enabling them to appreciate that there are alternative, equally valid approaches to, and means of, achieving 'success' in life. As such, young men can be supported in a process of personal growth and development towards a much more open and inclusive appreciation of meaningful participation and reward in life. Again, such care requires that MHPs do more than treat the 'condition' of suicidality. Care needs to take on an explicitly future oriented dimension, delivered over the longer-term. With this emphasis, a young man can, gradually and with the support of the MHP, come to appreciate the personal possibilities and opportunities that life has to offer.

In relation to the above point, one of the most compelling features of young men's talk about their experiences of care was frustration over what they saw as an inordinate amount of attention paid to the circumstances pertaining to their suicidality and the concomitant relative lack of attention paid to the means by which 'recovery' could be

achieved. The effect of this was to leave them dissatisfied with treatment and/or alienate them from it altogether. For most of the young men who voiced such frustrations, their main grievances centred on the failure to provide them with the cognitive and other (for example, social) skills and opportunities to be able to do so. Just as a preoccupation with their past contributed to the young men's sense of the futility of treatment, so a focus on moving forward into a potentially positive and rewarding future was seen by them as core to effective care. Consequently, the findings highlight the need to help and support young men to (re)discover and find (new) meaning in life and to instill in them a sense of hope for the future. They also show their need to obtain/refine pragmatic cognitive as well as social skills in the context of this meaningful engagement with life. These can include educational and work based skills.

The need for the development of cognitive resources/skills implicates the relevance of behavioural therapies (for example, Cognitive Behavioural Therapy (CBT) (Butler *et al.*, 2006) and Dialectical Behavioural Therapy (DBT) (Linehan & Dimeff, 2001)). These and other problem-solving approaches teach and reinforce adaptive coping skills, including the negative thinking associated with suicidality. The value of these types of therapeutic interventions in preventing (repeat) suicidal behavior has been endorsed in a recent review of interventions to prevent suicide conducted by the Scottish government (Leitner *et al.*, 2008), as well as other international research (Daniel & Goldston, 2009; Nordentoft *et al.*, 2005). Moreover, Crowley *et al.* (2004) stressed the need for interventions with youths that focus on developing their problem-solving skills and promoting their general coping skills. According to Clayton & Auster (2008), although each treatment is different, they are all reasonably short term as well as structured (increasing the ease with which therapies can be taught and delivered). These are two features likely to facilitate their adoption, including within current NI mental health service configuration. The availability of such therapies does, of course, require adequate numbers of appropriately trained counsellors. This is a prerequisite acknowledged in the recent New Horizons programme which aims to enhance access to psychological therapies across England (DoH, 2009). As has been highlighted by the findings of this study, cognitive (coping and adaptive) skills can be learned in a variety

of contexts, including the 'non-clinical' to which young men are naturally drawn (see also, Harden *et al.*, 2002). These contexts include opportunities for creative expression, leisure (sporting) and other forums of social interaction, including those available through self-help groups as well as on-line.

The need to equip young men with the social skills and opportunities to move on with their lives endorses the relevance of a Recovery approach to their care over the longer term. Indeed, taken overall, the findings indicate the value of this model of care because of the need to promote young men's real and perceived (by them) social inclusion as a necessary basis of their personal engagement with life. As has been highlighted recently (Higgins, 2008), the multi-dimensional concept of 'Recovery' has gained increasing acceptance as an appropriate orientation within mental health services. It can be understood as an individual process and/or outcome as well as involving the organisational/societal conditions in which recovery is made. Whilst Recovery is not something that professional carers can 'do', both they and members of society are viewed as having a fundamental role to play by creating an appropriately 'healing' environment. In terms of how this environment can be fostered, the recovery approach focuses on issues of citizenship, social inclusion, and service user- professional partnerships in all aspects of service planning, delivery and evaluation. The findings of this study endorse another central plank of the recovery approach, that is, the need to change public attitudes. These include stigma and discrimination (Higgins, 2008) typically associated with suicidal behavior and use of services.

Based on a wide ranging review of the literature, Higgins (2008) identified a number of principles underpinning a recovery approach. Significantly, the findings of the present study confirm these to be relevant to the care of young suicidal men. Amongst the most pertinent to this discussion are the following.

- '*optimism about recovery*' was repeatedly highlighted by participants as a necessary personal attribute of, and/or attitude displayed by, MHPs and others from whom they sought care and support.

- placing '*personal meaning*' (the uniqueness of each person, their experiences and social situation) at the heart of the therapeutic process (Barker, 2003; 2001) was underscored by participants' accounts of the therapeutic benefits they gained from an acknowledgement of them as human beings with relevant personal biographies and the tailoring of care to coincide with these biographies.
- '*person-centred services*' (a commitment to gaining a deep understanding of, as well as demonstrating respect for, the person holistically) was central to participants' reflections on the perceived value of care premised on manifest interest in them and genuine commitment to providing care based on an understanding of them 'in the round' and not just as a clinical 'condition'.
- '*service user operated services or peer support*' (partnership working between users and professional carers as well as peer support from those who have had similar experiences) fits entirely with participants' preferences for clinically oriented care premised on mutual respect and sustained interaction with those they had come to trust. The young men also highlighted the value of other forms of care involving those (peers) with similar experiences and consequent insight into/ability to provide relevant support. Crucially, study findings uphold the notion, central to the Recovery approach, that participants within a peer support programme benefit not only from being helped by others but also from helping others.
- '*social inclusion*' (an acknowledgement of a person's right to meaningful participation in social life, which addresses the wider social, attitudinal and economic barriers to citizenship), pervaded the findings including, for example, in relation to the need to remove barriers to participation such as (lack of) education and employment as well as societal barriers to inclusion, such as stigma and discrimination.

The views and experiences of the young men who participated in this study consistently endorsed the importance of strategies to tackle adverse social, economic and cultural circumstances which work to both undermine young men's mental health as well as impede their active participation in social life generally. The strategic and resource

implications of tackling these circumstances are, of course, significant but do not detract from its validity as an effective approach to the care (in its widest sense) of young suicidal men. They implicate the need for a range of different programmes and interventions, implemented across a diverse range of contexts and levels.

Taking all of the preceding issues into consideration, one of the most important implications to arise from the findings of this study is the need for the care of young suicidal men to extend well beyond the short-term, immediate identification of suicidal risk and concomitant treatment. Although similar conclusions have been reached in relation to other suicidal populations (Cutcliffe *et al.*, 2007), this is the first time that robust evidence has been delivered in relation to young suicidal men. Crucially, care needs to assume a much longer-term perspective. It needs to be based on an acknowledgement that recovery from suicidal behavior and ideation takes place gradually and only with continued support both from formal mental health services as well as other support networks. Significantly, this care is likely to be much more about equipping a young man to (re)connect with life, to appreciate and take advantage of the full range of opportunities life can offer, than it is about managing the risk of suicide.

5.3.1 Concluding comments

The findings of the present study uphold those of the earlier research in important ways and also provide significant *new* evidence in relation to the properties and processes of care relevant to suicidal young men. In terms of how findings confirm those of earlier research, they highlight the importance of the attitudes and demeanour of mental health professionals in forging a necessary interpersonal connection, involving empathy, openness and genuine concern. A therapeutic focus on the achievement of a meaningful *future* life has also been upheld. The findings of the study by Cutcliffe *et al.* (2006) resonate strongly with those of the present study in terms of a joint identification of a phased *trajectory* of care delivered over the longer-term, which responds to the changing circumstances and needs of suicidal individuals as they progress through the care process. Mental health professionals are centrally involved, alongside care and support delivered by significant others at both an individual and societal level.

In addition to the above, the present study contributes important *new* evidence concerning care of young suicidal men. Services which reach out pro-actively, that is, are open access, community based, informal and set within a context of social interaction are likely to encourage young men to engage initially and to remain engaged. This is because they fit with their preferences for clinical care as well as for interaction more generally. Further, support delivered by those with personal experience of/contact with suicide works on two fronts: as both a deterrent to engaging in (future) suicidal behavior as well as offering encouragement and confirmation that lives can be turned around for the better. Finally, the validity of the Recovery approach as an appropriate basis of care has been made clear. Young suicidal men, as individuals, need to be supported during their immediate suicidal crisis and beyond but an encompassing social environment, which promotes and facilitates opportunities for inclusion, also needs to be actively fostered.

Dowrick *et al.* (2009) recently completed a comprehensive and wide ranging review of evidence pertaining to the most effective configuration and delivery of mental health services for 'hard-to-reach' groups. As young suicidal men fall into this category on a number of fronts (Hendry, 2007), the evidence they review is of relevance to any discussion of how young men can be encouraged to engage with and benefit from mental health services. The authors identified three key concepts as relevant to the care of vulnerable, hard-to-reach groups *per se*, all of which are endorsed by the findings of our research.

Firstly, the idea of 'recursivity' captures how illness behavior is both enabled and constrained by the *interactions* that take place between individuals and health professionals in health service settings (Dowrick *et al.*, 2009). In particular, the ability of health professionals to communicate effectively with patients may reinforce or discourage health action in the future (see also, Biddle *et al.*, 2006). In this regard, the fundamental role and responsibility of health professionals in enabling young suicidal men to *stay* engaged and/or *reengage* with services as and when necessary has been

underscored by the findings of this study. Where young men perceived themselves to have developed a necessary relationship with their MHPs, their enthusiasm for and willingness to commit to care was obvious.

Second, 'candidacy' highlights how people's *eligibility* for health care is determined by a wide range of factors; core amongst these is the constant definition and redefinition by health services of the *legitimate* 'objects' of their attention (Dowrick *et al.*, 2009). The young suicidal men who participated in this study were constantly trying to make sense of themselves and their circumstances in relation to their 'appropriateness' for healthcare. Not only did their understanding of health services (as 'not for the likes of them') tend to work against engagement but, crucially, where they did (attempt to) engage, this was frequently further inhibited because of the configuration of services and/or the care they received. Based on their understandings of who were the legitimate candidates for services, young men tended to conceive of these as alien to what they wanted and/or required by way of care.

In this context, the final concept identified by Dowrick *et al.* (2009), that of 'cultural competence' highlights how clinicians need to take into account the individual values, beliefs and practices of patients and to base the care they provide around this 'patient-centredness'. The findings of this study support the need for the configuration of services and delivery of care to be similarly culturally competent. This means that they need to be designed and delivered in ways which fit with young men's core values, understandings and preferred modes of interaction.

5.4 Strengths and limitations of the study

The qualitative nature of this research was invaluable in enabling important new insight into the experiences of young suicidal men. As such, the findings contribute significantly to the evidence base concerning the form of services and content of care young suicidal men are likely to find of real benefit. Currently, no other study has reported such specific and detailed evidence.

The chosen qualitative research design for this study concurs with the widespread acknowledgement of the requirement to develop health services on the basis of what people themselves say. In line with the need to uncover this 'felt need' (Harden *et al.*, 2002), a range of young suicidal men talked about their views and experiences of (health) care. Their accounts have been used to create a number of related points as possible guides to the development of services specifically tailored to their needs and preferences.

This study is one of the few conducted that sought to listen to young men talk about their experiences of suicide and how they can be helped to move on to live full and rewarding lives. In so doing it provides important new evidence concerning how mental health services can be configured appropriately and how effective care can be provided within these services. As has been highlighted (Dowrick *et al.*, 2009), quantitative evidence, for example, that derived from randomised trials, can provide valuable information about what works and for whom, but is of limited help in explaining why. Consequently, qualitative sources of evidence are required to uncover why current practices (may not) work, and what can be done to improve them. The face-to-face, in-depth interviews were extremely valuable in advancing relevant knowledge about a group of people who are notoriously difficult to reach (Hendry, 2007).

Although the study was successful in involving young men who had availed of services as well as those who had not, the potential for bias remains. While we engaged young men who had contact with/experience of statutory services, they were self selecting in so far as they entered the study through the media/advertising strand of recruitment (see Chapter Three: Methodology). Consequently, these young men may have been motivated to participate for quite specific reasons, and presented a particular 'take' on services and the care embedded within them. The potential for bias arises because of the lack of young men who entered the study through statutory services.

Problems were encountered recruiting from within statutory services, both in relation to young men currently engaged as well as those who had disengaged. Concerning the

latter group, it proved impossible to actively recruit due to logistical issues relating to Trust databases (see Chapter Three: Methodology). Concerning young men currently engaged with services, a comprehensive and diverse programme of activities was undertaken to maximise the possibilities/opportunities for their recruitment, including (recurrent rounds of) meetings with/presentations to relevant (teams of) clinicians and management throughout the entire lifespan of the study. Despite these efforts and the repeated assurances given by relevant clinicians and managers that recruitment of young men was being actively pursued, rates of recruitment from statutory services in both the Belfast and Southern HSC Trusts remained low.

Problems were encountered also in relation to recruiting from within community sector services within the north and west Belfast area. Interestingly, no problems were encountered in the Southern Trust area. Again, a comprehensive and diverse programme of activities was undertaken to maximise the possibilities/opportunities for recruitment from community sector services in the north and west Belfast area. This included regular meetings with/presentations to counsellors and management throughout the entire lifespan of the study. Although concerns over the vulnerability of young men were expressed, assurances were given that help with recruitment would proceed. This did not happen and we concluded that some community organisations based in north and west Belfast were unwilling to refer young men into the study.

The possible reasons for low rates of recruitment include:

- (a) the period of active recruitment coincided with fundamental changes to staff structures and systems of operating within the newly instigated Belfast and Southern Health and Social Care Trusts. Teams (clinical and management) were being dismantled and new ones established. This meant that it was difficult to navigate around the emerging structures and systems and many of the posts remained unfilled during the lifetime of the study. Both these issues mitigated against timely decision-making regarding how services could advance recruitment to the study;

- (b) the exclusion criteria explicitly precluded the involvement of young men deemed to be 'currently suicidal'. Furthermore, clinicians and counsellors were advised verbally and in writing that they should not approach any young man considered to be emotionally vulnerable. Nonetheless, it may be that they remained reluctant to make an approach for fear of instigating a deterioration in a young man's mental health and/or interfering with the therapeutic process/relationship;
- (c) irrespective of their goodwill and in the context of existing heavy workloads, it appeared that clinicians/counsellors and management had difficulty 'remembering' to refer relevant young men to the research team.

Despite these issues, the study was successful in recruiting young men with a relevant range of contact with/experience of services. Consequently, the research delivered a robust dataset to provide the comprehensive set of findings presented in Chapter Four. It is of particular note that the strand of recruitment based on a comprehensive media and other advertising campaign (see Chapter Three: Methodology), was *very* successful in terms of numbers of young men coming forward for inclusion in the study. This success highlights the willingness of young (suicidal) men to participate in research **if** given the opportunity to so do. The study operated under quite specific parameters set by the local ORECNI committee concerning how young men could be accessed prior to them giving explicit consent for an initial approach by a member of the research team to be made. It is of note that very few young men choose not to participate in the research once this approach had been made. Bearing in mind this willingness on the part of young men to participate in the research, it is likely that had the research team been able to approach young men currently and previously engaged with services more *directly*, the rates of recruitment would have improved. Although the efforts of ORECNI to ensure the safety of young suicidal men are entirely understandable, the conditions of access thus set meant that a disproportionate amount of time was spent on ensuring that the understandings and perspectives of young men who had voluntarily disengaged from mental health services were included.

5.5 Recommendations: policy and practice relating to the provision of care for young suicidal men

The following recommendations for policy and practice are drawn directly from the views expressed by the 36 young men who participated in the study. The order of presentation does not reflect their relative merits; all should be taken as fundamental components/ dimensions for the delivery of effective care.

5.5.1 Recommendations for Further Research

It is recommended that studies are funded and undertaken in the following areas:

- A study focusing on the understandings and experiences of health care professionals caring for suicidal (young) men.
- An exploration of the effectiveness of care delivered by health care professionals trained in the provision of care focused on meeting the emotional and interpersonal needs of young suicidal men, that is, on helping them to *reconnect with humanity*.
- A study focusing on the components/dimensions for effective care for older suicidal men.
- An exploration of how types of media that have become a regular means of communication between young people could be used in suicide prevention work (e.g. social networking websites, texting and email).

5.5.2 Recommendations for Practice

- It is essential that health care professionals care for young suicidal men in ways which respond to their basic emotional and interpersonal needs. It should be ensured that health professionals possess and convey therapeutic and supportive (non-judgemental) attitudes and realise the important bonding role they have in enabling young men to *reconnect with humanity*.

- Health care professionals should appreciate that their demeanour and attitude is crucial to a young man's sense of meaningful therapeutic engagement. Effective care is as much about how a young man perceives the relationship between himself and professional carer as it is about the 'technical' components of care.
- Care should be premised on an explicit acknowledgement of a young man as a human being with a unique personal biography.
- It should be ensured that treatment and care is relevant to recovery and onward trajectory through life if it is to be perceived as effective by young men. As part of this sense of 'moving forward', care should include help and support to develop a realistic appreciation of the (personal) possibilities that life offers as well as the skills to pursue these possibilities once envisaged.
- Psychological therapies need to be made available as part of routine care, particularly those that equip young men with fundamental cognitive resources, including coping strategies (e.g. for dealing with stress, anxiety and disappointment) as well as other dimensions of mental/emotional well-being such as, for example, self-esteem.
- Care should be premised on a recovery rather than a 'risk reduction' approach.
- Additional education/training needs to be provided to health care professionals in order to support the provision of relevant care to young suicidal men.

5.5.3 Recommendations for Policy Makers

- It should be ensured that services should be accessible to young men and that perceived barriers to access, as have been identified by this research, are removed as a matter of urgency.

- Services and care should be premised on an acknowledgement of the need for support to be provided to young men over the long-term so that they are to be enabled to move forward with their lives in a positive manner once the initial risk of suicide has been removed.
- Novel forms of suicide prevention outreach work should include those media that have become a regular means of communication among young people. This includes social networking systems, the Internet, 'text messaging' and/or email.
- Services must continue to address the concerns of young men about issues of stigma and confidentiality regarding the care and treatment of suicidality. Some issues around signposting and labeling of suicide prevention services should be addressed immediately.
- Suicide related services need to reach out to young men *pro-actively*. These services should be community based and open-access.
- Part of this pro-active, community level service provision should be embedded in manifestly non 'mental health' contexts. These include sports clubs, schools, the workplace and community interest/self-help groups. Relevant care should be based on a broad recovery approach.
- Irrespective of the particular form of care/service provision, help and support needs to be delivered by those appropriately skilled and resourced.
- Services, particularly those based in the community, need to be advertised more widely and in ways which reach out to young men. A range of media should be used to promote access and provide culturally relevant care, including media which have become a regular means of communication amongst young people.

- People with experience of suicide should be involved in care delivery and support. Hearing *first-hand* about these experiences serves as a powerful disincentive to suicide and learning about lives built successfully thereafter can act as an incentive for/basis of personal growth and development.
- Maximising access must include taking steps to address the major challenges posed by stigma and discrimination, including comprehensive, population-level advertising and awareness raising campaigns as well as more targeted educational and workplace initiatives. Although important, it must be appreciated that, on their own, these programs are of limited value in decreasing stigma and discrimination.
- The need to skill and support young men operates at both an individual and societal level and a fundamental part of this must involve creating an appropriate environment to promote participation and social inclusion of young suicidal men generally.

Conclusion

The findings of this study corroborate some of the core principles enshrined in national suicide prevention strategies of many western countries. These include: the United States (USDHHS, 2001), England (DoH, 2002), Scotland (The Scottish Executive, 2002), Ireland (HSE, 2005), New Zealand (Associate Minister of Health, 2006) and Australia (ADGHA, 2000). All have been developed in direct response to a significant global increase in the rate of suicide. Examination of these documents shows much conceptual and strategic overlap and corresponding similarities in emphases in relation to priorities set for the prevention of suicide. One such emphasis is that of interventions to help combat the stigma associated with suicide. Our research shows this to be particularly pertinent to the uptake and utilisation of mental health services among young men in Northern Ireland.

Encouragingly, there is evidence that national suicide prevention strategies can be effective in reducing the rate of young male suicide. For example, Morrell *et al.* (2007) traced a reduction in suicide in young men in Australia to the National Youth Suicide Prevention Strategy (NYSPS). This strategy ensured that health and social care providers were resourced to implement a wide range of national and local-level interventions across primary prevention programmes, capacity building services and treatment support. Further, Stark *et al.* (2008) suggested that the recent priority given to promoting mental health and well being in Scotland, as part of the national suicide prevention strategy work, may have had an impact on reducing young male suicide. Specific interventions which mirror the policy and practice recommendations outlined in respect of this study include the 'See Me' anti-stigma programme, the 'Breathing Space' confidential telephone helpline targeted at young men, the development of a recovery-oriented mental health programme (the Scottish Recovery Network), as well as a large investment in media publicity about the nature and prevalence of suicidal behaviour.

Underpinning the development of the *range* of programs and related measures included in national suicide strategies has been the ongoing debate concerning the most

appropriate approach to suicide prevention. Whilst a public health approach within suicide prevention is necessary in that it permits a broad range of social, economic, health, mental health, cultural and other risk factors to be integrated and targeted (Jenkins & Singh, 2000; Jenkins, 2002), the need remains for more targeted interventions (Beautrais *et al.*, 2005), including and particularly in relation to identified high-risk populations such as young men.

The evidence from our study highlights the importance of implementing a 'package' of measures. These include Northern-Ireland wide, population-level public health measures directed at reducing the stigma and discrimination associated with suicidal behavior and related help-seeking. In addition, measures should be targeted specifically at the 'at risk' population of young men themselves (for example, care which is specifically configured around the help-seeking preferences of young men). These measures are inextricably linked; put basically, young men have to 'turn up' for care in order for that care to have a chance of being effective. They will continue not to attend services they perceive as both stigmatised and stigmatising irrespective of the quality of care these services may provide. However, as outlined above, there is growing evidence that, once implemented, such measures can be effective in reducing young male suicide.

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Appendix One: Participant Information Sheet
Participant Consent Form

PARTICIPANT INFORMATION SHEET

Title of the study

Using the experiences of men who have considered suicide to help improve health care

Your involvement in this study

You are being invited to take part in a research study. Before you decide if you wish to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask if there is anything that is not clear or if you would like more information. Take time to decide if you want to take part.

Purpose of this study

The aim of the study is to undertake interviews with men who have been or are currently suicidal. The information collected through the interviews will be used to help plan health services in Northern Ireland by making recommendations on how to best care for people who are suicidal. The study will be undertaken jointly by the Queens University of Belfast and the University of Ulster. In total, the study will last for two years.

Do I have to take part?

It is up to you to decide whether or not to take part. If you decide to take part, you will be given this information sheet to keep and will be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. **When you are thinking about whether or not to take part it is important that you know that your decision will make no difference whatsoever to the care you are currently receiving.**

What does participation in this study involve?

Participation in the study means talking to a trained interviewer about your views and experiences on:

- things that have happened in your life that have influenced your thoughts about suicide
- the types of help and support that you have used when you have been feeling suicidal

The interview will take place at a time and a place that suits you. We hope to record the interview so that we obtain as accurate a record of your views and experiences as possible. However, if you would rather the interview was not recorded, then please feel free to say so and a recorder will not be used. The researcher and you will agree all the arrangements before the interview.

Will my taking part in this study be kept confidential?

Yes. All information collected will be kept strictly confidential. Your name will not appear in any results of the study.

The only circumstances in which information you give during an interview would be disclosed to family members is if you die within five years after the interview and they begin legal proceedings to obtain the transcript of your interview. Family members will not be offered or given the transcript under any other circumstances.

What are the benefits of taking part in this study for me?

The benefits of taking part in the study are that you will:

- have the opportunity to have your voice heard about an important issue affecting many people in Northern Ireland today
- get information about local support services and groups which you may choose to use now or in the future
- have the opportunity to have your needs and wishes taken into account when planning services for people who are suicidal
- help improve services for people who are suicidal.

What are the risks of taking part in this study for me?

It may be that you become upset or distressed as a result of the interview, for example, by being asked to talk about painful personal events or experiences which could lead to you needing professional support or help. If this happens, the interview will be stopped and the interviewer will help you to decide what support you need and, if necessary, give you practical help to access this support. Also, if the interviewer feels that you are so upset that you are at risk of hurting yourself or others, the emergency services will be contacted immediately.

What support will I receive during participation?

If you take part in the study, you will be offered counselling free of charge with a qualified and accredited counsellor (British and Irish Association of Counselling and Psychotherapy) who will have a contract with research team.

Who is funding this study?

This study is funded by the Research and Development Office for Northern Ireland.

What happens to the results of this study?

The results of the study will be written up in the form of a report which will be sent to the appropriate health services for them to read. The results will also be published in journals. A newsletter outlining the results will be sent to all of the people who took part in the study and be available within the community.

What should I do if I have any more questions?

If you have any questions about the study or your role in it, please contact Sinead Keeney on 028 90 368463 or on email sr.keeney@ulster.ac.uk

What happens next?

If you decide to take part in the study, your name and telephone number or email address will be passed on to the researcher who will contact you **to discuss the study in more detail, answer any questions you might have and, if appropriate,** set up a suitable time and date for interview.

THANK YOU FOR TAKING TIME TO READ THIS INFORMATION SHEET

PARTICIPANT CONSENT FORM

TITLE

Using the experiences of men who have considered suicide to help improve health care

OUTLINE EXPLANATION

The aim of this study is to explore the experiences of men aged between 16 and 34 years who have thought about and/or attempted suicide.

Your participation in the study will involve taking part in an interview in which you will be asked about your experiences of life and how these have affected you, including how you have considered suicide.

The interview will last approximately one hour. Anything that you say will be entirely confidential and at no time in the study will you be identified by name to anyone other than the researcher who will interview you. Any comments included in the final report will not be attributed to any one individual.

LIMITS OF CONFIDENTIALITY:

The only circumstances in which information you give during an interview would be disclosed is:

- **if the interviewer feels that you are so upset during an interview that you are at risk of hurting yourself or others, the emergency services will be contacted immediately**
- **if you die within five years after the interview and family members begin legal proceedings to obtain the transcript of your interview. Family members will not be offered or given the transcript under any other circumstances.**

CONTACT:

If you wish to discuss any aspect of this with a member of the research team, please do not hesitate to contact Sinead Keeney on 02890 368463 or email sr.keeney@ulster.ac.uk who will be happy to answer your questions.

COUNSELLING:

Counselling will be provided for you free of charge if you wish to take up this opportunity. The researcher will give you details about this.

CONSENT

I confirm that I have read and understand the Participant Information Sheet, **(dated 10th July 2007, (Version number 4)** for the study *Using the experiences of men who have considered suicide to help improve health care*, and have had the opportunity to ask questions.

I understand that my participation is entirely voluntary and that I am free to withdraw from the study at any time, without giving a reason **and with no effect on the care I am currently receiving.**

I consent to take part in the study.

Signed: _____

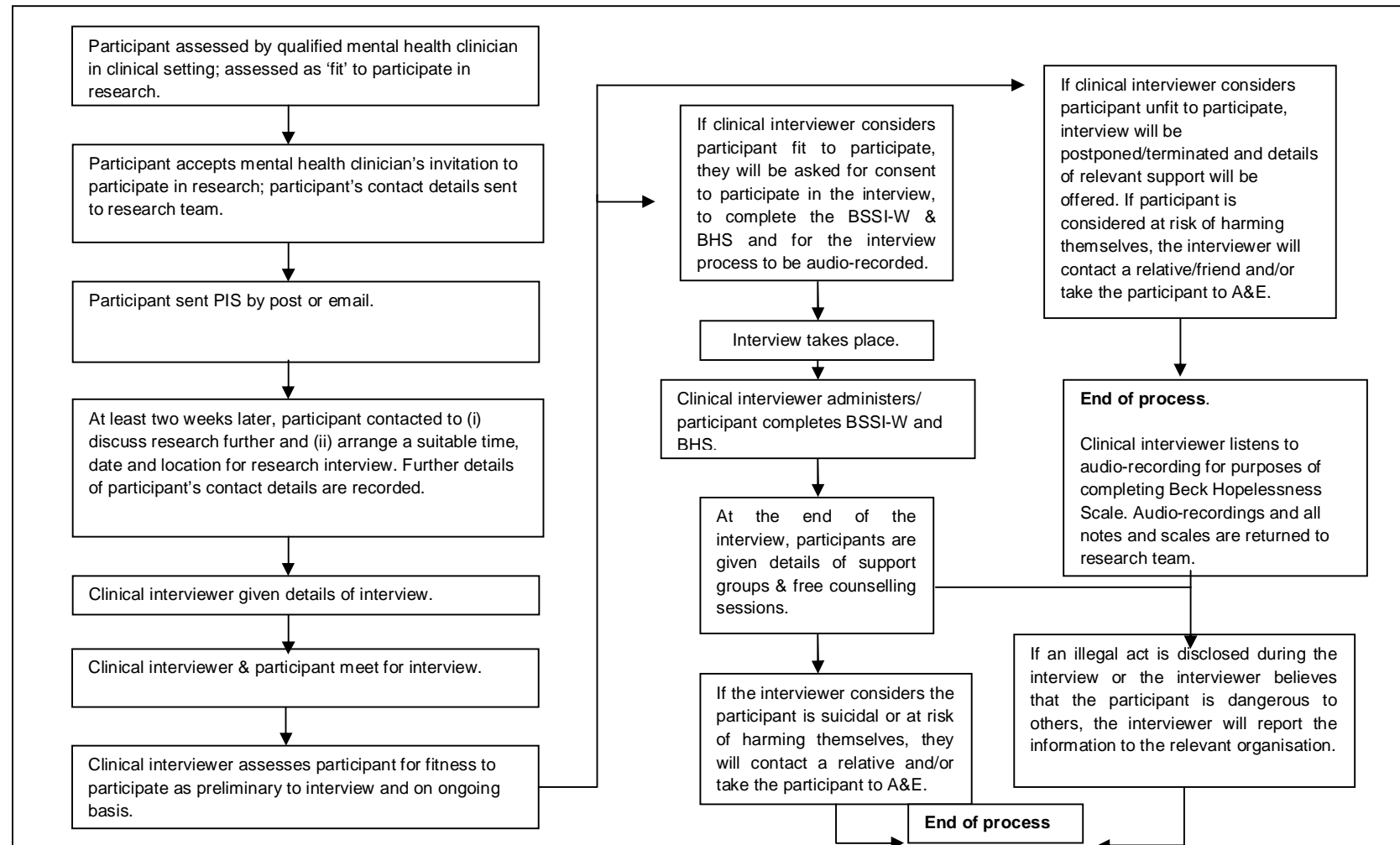
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Witnessed by: _____

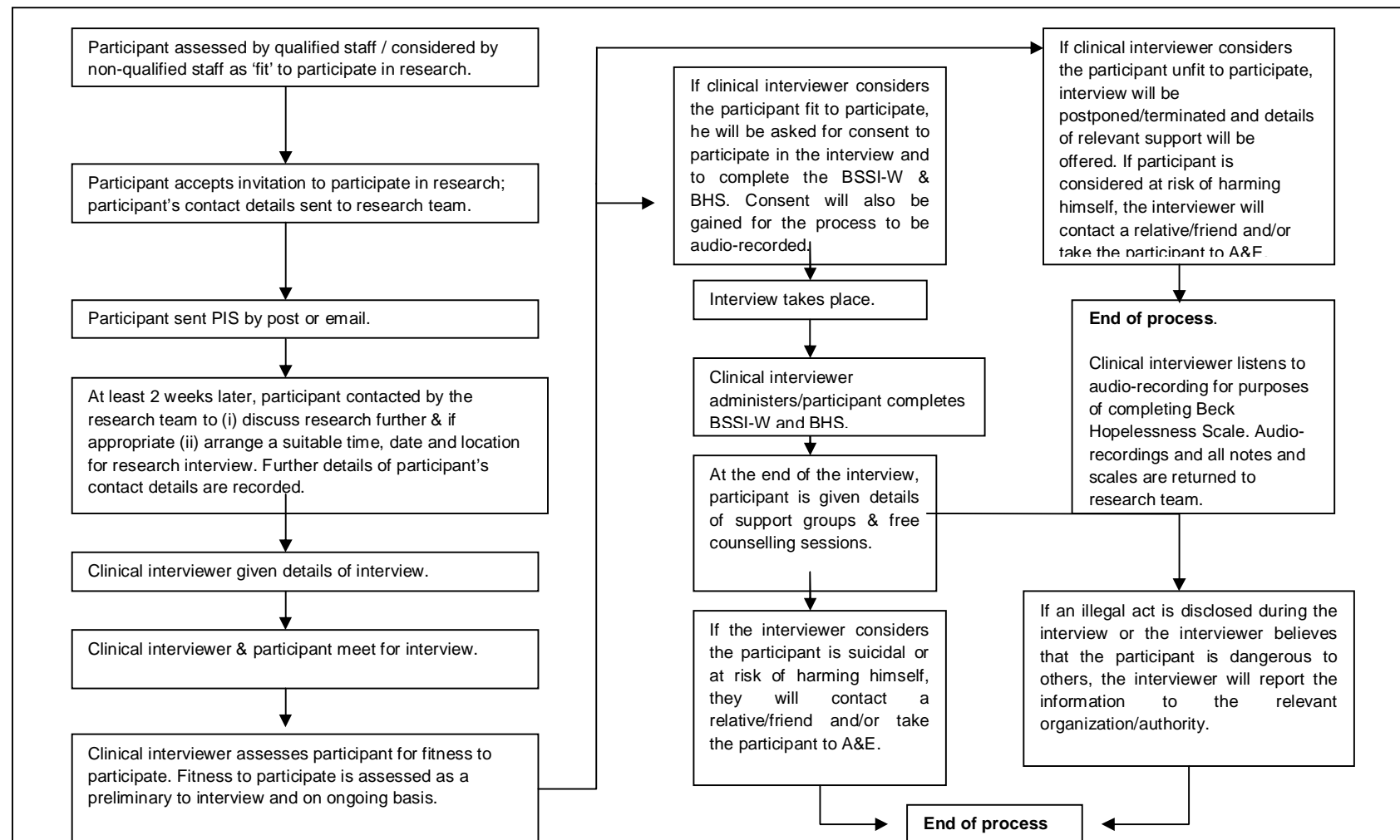
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Appendix Two: Flowcharts: Participant entry into, participation in and exit from study

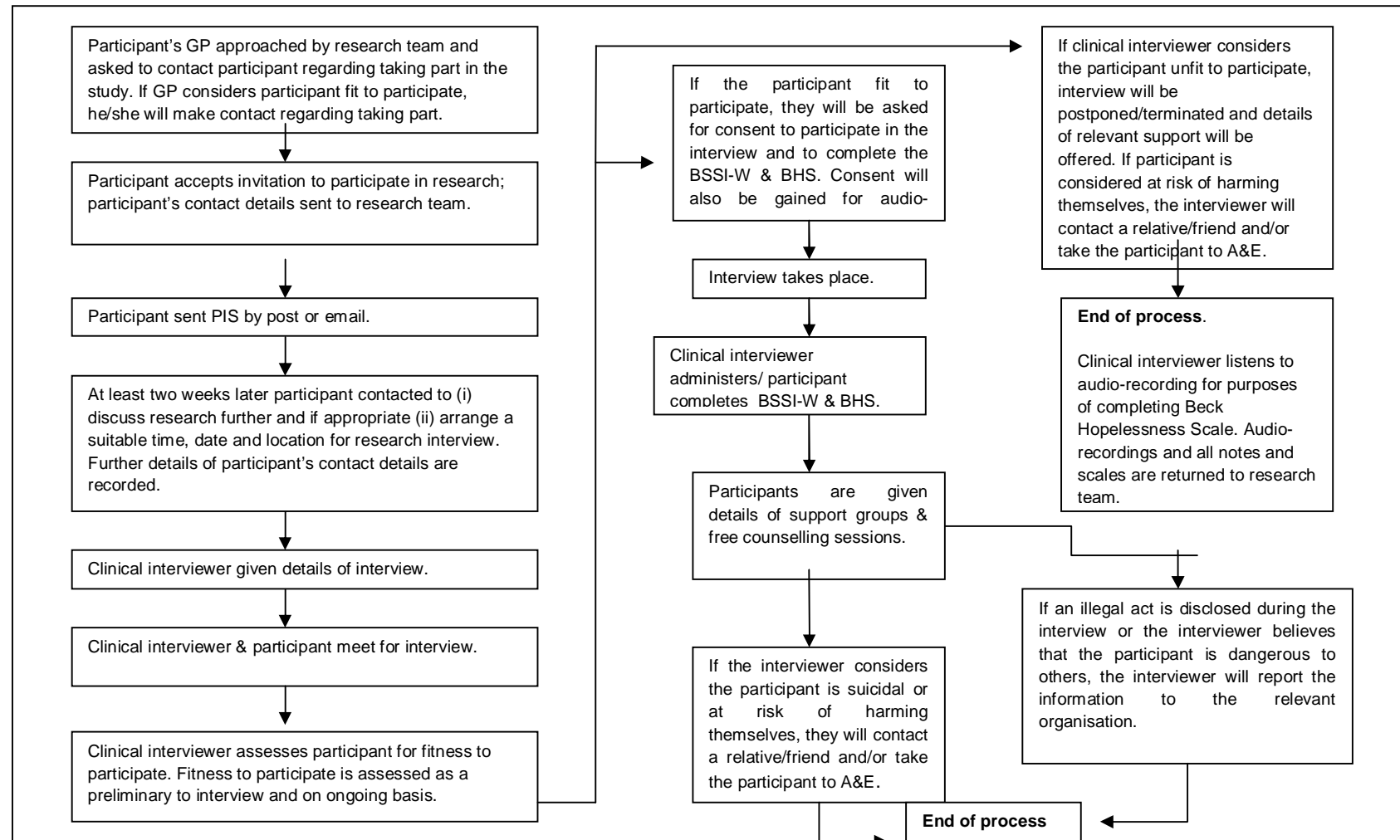
Protocol for dealing with suitable and unsuitable participants referred from statutory services



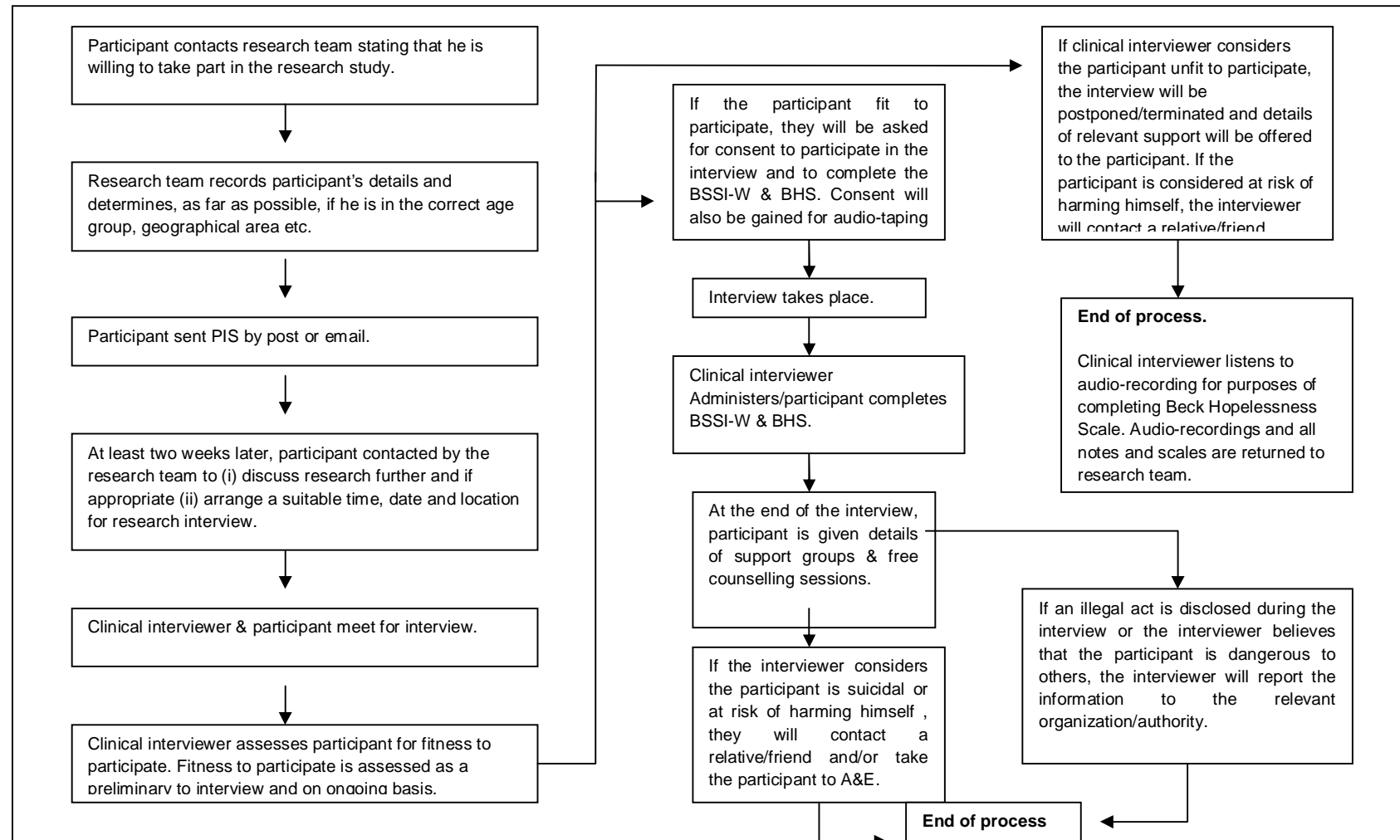
Protocol for dealing with suitable and unsuitable participants referred from voluntary or community services



Protocol for dealing with suitable and unsuitable participants who have engaged with statutory services in the past



Protocol for dealing with suitable and unsuitable participants recruited from media calls



Appendix Three: Study Advertisement



SUICIDE AND YOUNG MEN IN NORTHERN IRELAND

Queen's University Belfast and the University of Ulster are conducting research into the experiences of young men and suicide in Northern Ireland. The geographical areas this stage of the study is focusing on are North and West Belfast.

If you are male, aged between 16 and 34 years, have thought seriously about or acted with the intention of suicide and live in North or West Belfast, we would like to talk with you.

Being involved in the research will mean telling us about your views and experiences of, for example:

- things that have happened in your life that have influenced your thoughts about suicide
- the types of help and support you have used when you have been feeling suicidal.

An interview to talk about these things will take place at a time and a place that suits you.

Taking part in this study means you will:

- have the opportunity to have your voice heard about an important issue affecting many people in Northern Ireland today
- get information about local support services and groups which you may choose to use now or in the future
- help to improve services for people who are suicidal.

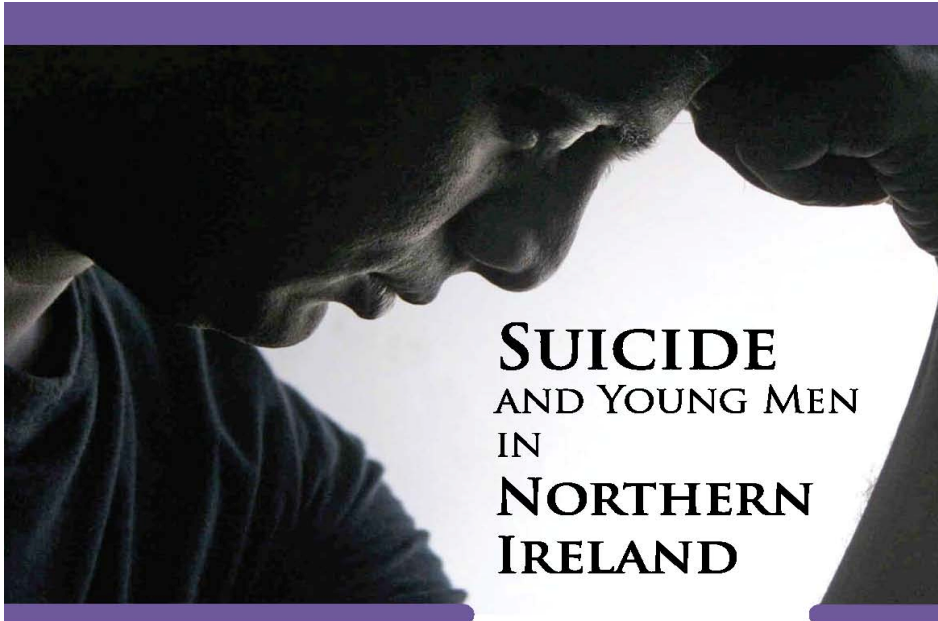
If you take part in the study, counselling with a qualified and accredited counsellor (British and Irish Association of Counselling and Psychotherapy) will be available should you require it.

Anything you tell us will be in strict confidence meaning your name will never be known to anyone other than the person who arranges your interview and the researcher who will interview you.

If you have any questions about this study or think you would like to take part, please contact Iain on 07894 646690 or email us at menssuicidestudy@ulster.ac.uk



Appendix Four: Study Poster



SUICIDE AND YOUNG MEN IN NORTHERN IRELAND

The Queens University of Belfast and the University of Ulster are conducting research into the experiences of young men and suicide in Northern Ireland. The geographical areas that this stage of the study is focusing on are North and West Belfast.

If you are male, aged between 16 and 34 years, have thought seriously about or acted with the intention of suicide and live in North or West Belfast, we would like you to talk with us.

Being involved in the research will mean telling us about your views and experiences of, for example:

- things that have happened in your life that have influenced your thoughts about suicide;
- the types of help and support that you have used when you have been feeling suicidal;
- what types of support you would like.

An interview to talk about these things will take place at a time and a place that suits you. The researcher and you will agree all the arrangements beforehand.

Taking part in this study means that you will:

- have the opportunity to have your voice heard about an important issue affecting many people in Northern Ireland today;
- get information about local support services and groups that you may choose to use now or in the future;
- help to improve services for people who are suicidal.

If you take part in the study, counselling with a qualified and accredited counsellor (British and Irish Association of Counselling and Psychotherapy) will be offered to you should you require it.

Anything that you tell us will be strictly confidential, meaning that your name will never be known to anyone other than the person who arranges your interview and the researcher who will speak with you.

If you have any questions about this study or think you would like to take part please contact one of the research team, **Iain McGowan** on **07894646690** or email us at: **menssuicidestudy@ulster.ac.uk**.